DOCUMENT RESUME

ED 306 416	CE 052 382
TITLE	Workshop for Key Staff of Geriatric Education Centers (4th, Houston, Texas, April 21-24, 1988). Workshop Report.
INSTITUTION	Texas Consortium of Geriatric Education Centers, Houston.
SPONS AGENCY	Health Resources and Services Administration (DHHS/PHS), Rockville, MD. Bureau of Health Professions.
PUB DATE	Apr 88
CONTRACT	HRSA-240-87-0071
NOTE	109p.
PUB TYPE	Collected Works - Conference Proceedings (021) -- Reports - Descriptive (141)
EDRS PRICE	MF01/PC05 Plus Postage.
DESCRIPTORS	Aging (Individuals); Delivery Systems; *Educational Gerontology; *Federal Programs; *Geriatrics; Postsecondary Education; *Program Administration; *Program Development; *Staff Development
IDENTIFIERS	*Geriatric Education Centers

ABSTRACT

This document contains an executive summary and the report of the workshop. An overview highlights major events and outcomes of the workshop. Major addresses and the staff development sessions that occurred at a workshop for key staff of geriatric education centers (GECs) are discussed. Summaries of presentations include the following: "Welcome, Introductions, and Review of Purposes" (Roush, Gleich); "Federal Perspective of National GEC Program" (Louden, Gleich); "Management of Geriatric Education Centers" (Louden, Koenig, Gleich); "Program Development" (Saunders, Feather, Teitelman); "Evaluation Strategies" (Karuza, Hubbard, Torian); "Models in Geriatric Education: Impressions and Concerns" (Prothero, Groth, Sanchez); "Strategies to Promote Education in Geriatrics" (Connelly, Parlak, Nelson); "Accessing Educational Resources" (Davis, Mellor, Gardner); "Establishing Community Linkages" (Marshall, Noback, Tryon); "Relationship of Geriatric Education to Service Delivery Models" (Abrass, panel discussion--Hughes, Dimond, Luchi); "Linkage Binding; Evaluation; Curriculum; Issues and Trends" (Saunders et al.); Discussion of Transition of Task Forces to Work Groups; "Issues in Geriatric Education" (Hatch, panel discussion--Besdine, Dobrof, Pfeiffer); GEC Staff Development Sessions and Group Reports to Plenary Sessions; "The Role of GECs in Community Development" (panel discussion--Brasfield, Haber, Rankin, Oppenheimer); "Future Directions for Geriatric Education Centers" (panel discussion--Calkins, Beck, Kowal, Fulmer). A list of participants' names and addresses is included. (KC)

****
*   Reproductions supplied by EDRS are the best that can be made   *
*   from the original document.   *
****

ED306416

WORKSHOP REPORT

Fourth Workshop for Key Staff of
Geriatric Education Centers

Houston, Texas

April 21-24, 1988

Prepared by the Staff of

The Texas Consortium of Geriatric Education Centers

Baylor College of Medicine
Houston, Texas

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☑ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

● Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

R Roush

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

CE052382

The report was prepared in partial fulfillment of contract HRSA 240-87-0071 from the Bureau of Health Professions, Department of Health and Human Services. Any view expressed or statements made herein are those of the workshop presenters and/or staff editors and do not necessarily reflect the official position of HRSA or the Bureau of Health Professions.

BEST COPY AVAILABLE

EXECUTIVE SUMMARY

Fourth Workshop for Key Staff of Geriatric Education Centers

Houston, Texas

April 21-24, 1988

Prepared by the Staff of

The Texas Consortium of Geriatric Education Centers

Baylor College of Medicine
Houston, Texas

The report was prepared in partial fulfillment of contract HRSA 240-87-0071 from the Bureau of Health Professions, Department of Health and Human Services. Any view expressed or statements made herein are those of the workshop presenters and/or staff editors and do not necessarily reflect the official position of HRSA or the Bureau of Health Professions.

FOURTH GEC WORKSHOP EXECUTIVE SUMMARY

SECTION PAGE

I. Preface and Acknowledgements.................................i

II. Overview of the Workshop..................................ii

III. Summary Remarks..vi

I. PREFACE AND ACKNOWLEDGEMENTS

We are grateful to the many people who had a part in the success of the Fourth Workshop. We wish to thank the project officer, staff, committee members and others who gave so much of their time, experience and skills to this worthwhile effort.

Project personnel from the TCGEC included **Robert Roush, Ed.D., M.P.H.**, Project Director; **Carl E. Fasser, B.S., PA-C**, Co-Project Director; **Teresa L. Wright, M.P.H. candidate**, Workshop Coordinator; and **Sherry McDonnell**, Workshop Secretary. The Bureau of Health Professions' Project Officer for the contract was **Carol Gleich, Ph.D.** Other persons from the Bureau of Health Professions who participated included **Thomas Louden, D.D.S.**, Director, Division of Associated and Dental Health Professions, **William Koenig, M.P.A.**, Chief, Geriatric Education Section, Division of Associated and Dental Health Professions and Mr. **Thomas Hatch**, Associate Administrator for Policy Coordination, HRSA. Secretarial and administrative support provided the project was given by **Mrs. Darla DiStefano** and **Mrs. Iris Cox**.

The project staff also benefited greatly from the expertise and insight of the following members of the Workshop Planning Committee: **John Feather**, Ph.D., Associate Director, Western New York GEC; **Linda Brasfield, M.S.**, Director, OVAR GEC; **Michele Saunders, D.M.D., M.S., M.P.H.**, Director, South Texas GEC; **Itamar Abrass, M.D.**, Director, Northwest GEC; **Eric Pfeiffer, M.D.**, Director, University of South Florida GEC; and **James O'Brien, M.D.**, Director, GEC of Michigan.

Special thanks go to **Ms. Joan Easton, Ms. Betty Tindall** and staff of the Houstonian Hotel and Conference Center, the staff of the Holiday Inn Crowne Plaza Hotel in Rockville, Maryland, Travel House Travel Agency, **Mr. Audie Thor** of Marion Laboratories, Ninfa's Catering, Kinko's Copying, Continental/Eastern Airlines, GRAY LINE of Houston, the Office of Auxillary Enterprises of UTHSC-Houston, Marachi Los Gallitos, and the business office of Baylor College of Medicine.

Final thanks must be extended to the representatives of each GEC who attended the workshop. Their contribution as a speaker or session participant stands as testimony to their enthusiasm and commitment to the GEC network and to the overarching goal of providing quality health care services to elderly individuals. As project director, I want to again recognize the contribution of Teresa Wright and Carl Fasser whose efforts made the workshop the success that it proved to be. I count it a privilege to have worked with and learned from such an august group of individuals as those who were in attendance at the fourth workshop.

Robert E. Roush

Robert Roush, Ed.D., M.P.H.
Director, Texas Consortium of Geriatric Education Centers
and Project Director, Fourth Workshop
Baylor College of Medicine

II. OVERVIEW OF THE WORKSHOP

On October 15, 1987, Dr. Roush and Mr. Fasser met with Dr. Gleich in her office in Rockville, Maryland to finalize such matters as the membership of the planning committee and the date of the first planning meeting.

The six-member planning committee, TCGEC project staff and BHPr project officer met in Washington, D.C., on January 20, 1988 to finalize the content, presenters, format and agenda for the April workshop. A non-federally sponsored data gathering instrument was sent to each of the directors of the thirty-one GECs and to each person who would be attending the workshop in April. Eighteen of the GECs responded to this request for ideas for topics: from this information the areas of interest to prospective attendees were identified.

On April 21-24, 1988, a total of 112 participants, 27 of whom were representatives from the nine new GECs, gathered for the Fourth GEC Workshop at the Houstonian Hotel and Conference Center (refer to Section V, List of Participants, Final Workshop Report). The nine new grantees were California GEC, Creighton Regional GEC, GEC of Michigan, Great Lakes GEC, New Mexico GEC, Pacific Islands GEC, Stanford GEC, University of Florida GEC, and the University of South Florida GEC. All 31 GECs were represented at the meeting, with some centers bringing as many as five representatives.

Beginning Thursday afternoon, April 21, an orientation was held for representatives of the nine new GECs. These individuals were welcomed by Drs. Robert Roush and Carol Gleich and then briefed on the federal perspective and management of the GEC program by Drs. Thomas Louden, Carol Gleich, and Mr. William Koenig. A session on program development followed: Dr. Michele Saunders facilitated the discussion by Drs. John Feather and Jodi Teitelman. Subsequently, Drs. Jurgis Karuza, Richard Hubbard, and Lucia Torian discussed the importance of evaluation strategies and the use of the GEC Reporting Mechanism developed at Case Western Reserve GEC. This first day concluded with a reception and dinner at the Houstonian Hotel and Dr. John Wolf, Chairman of Dermatology at Baylor, gave a lecture entitled "Our Aging Skin."

Continuing on Friday morning, 22 April, the orientation for the nine new GECs included two staff development sessions and two technical assistance sessions that were designed so that each representative could attend one from 8:30 - 10:00 a.m. and another from 10:15- 11:45 am. The development sessions were entitled: "Models in Geriatric Education: Impressions and Concerns" and "Strategies to Promote Education in Geriatrics." The technical assistance sessions addressed "Accessing Educational Resources" and "Establishing Community Linkages." Keypoints made by representatives of then current GECs for the attendees representing the new ones were to network with existing GECs to avoid mistakes made in implementing first-year activities; to be introspective about identifying local resources and build around particular institutional strengths; to develop clear lines of communication within the university and to the community served; develop an evaluation based on the programs unique to the GEC but which is consistent with the emerging GEC system-wide protocol to describe the various categories of enrollees; and to utilize others' resources, e.g., literature and curriculum guides.

Registration for all thirty-one GECs began at 11:30 am on Friday, 22 April. Drs. Robert Roush, Thomas Louden and Carol Gleich gave the opening remarks to the audience participants. The keynote speaker, Dr. Itamar Abrass of the Northwest GEC, gave the plenary session address, "Relationship of Geriatric Education to Service Delivery Models," the implications of which were discussed by a panel. Key points made by Dr. Abrass and panelists Drs. Robert Luchi, Margaret Dimond, and Glen Hughes were the acute hospital, as a setting for geriatrics training, is not adequate, i.e., community-based settings must be used; field experiences should be generalizable, students must work with well elderly persons; and the chief focus should be prevention based on age-adjusted standards that emphasize quality of life issues.

Task force reports to the plenary session were designed to provide an overview for the attendees of earlier task force activities, accomplishments since the Third Workshop, and areas remaining in need of attention. The reports were made by these individuals:

Dr. Michele Saunders, Linkage Building
Dr. Jurgis Karuza, Evaluation
Ms. Davis Gardner, Curriculum
Dr. Gloria Barry, Issues and Trends

With the assistance of TCGEC recorders, four designated facilitators convened a gathering of interested GEC representatives to consider the actions of the new work groups. The Friday afternoon session concluded with an eight-minute report by each facilitator of the major points and recommendations that were discussed.

The transition from task forces to work groups resulted in the following:

The Linkage and Communication Work Group was facilitated by Dr. Gloria Barry. Key recommendations made were to (a) continue annual GEC meetings at GSA, (b) encourage use of the Alabama GEC's electronic bulletin board, (c) solicit support from HRSA to have an exhibit booth at national meetings to communicate national GEC activities, and (d) the GEC of Pennsylvania will continue to serve as the focal point for this workshop activity.

The Project Assessment Work Group was facilitated by Dr. Deborah Simpson. Key recommendations made were to (a) suggest a centralized clearing house to share information about evaluation models, (b) an appropriate focus for combined evaluation efforts could be the multidisciplinary aspect of all GEC programs, and (c) Dr. Molly Engle of UAB will serve as the coordinator of the work group.

The Geriatric Education Work Group was facilitated by Dr. Lucille Nahemow. The key recommendation made was to continue development of a monograph summarizing case studies of various GEC projects, and that Dr. Nahemow of the Connecticut GEC would serve as liaison for this work group.

The Policy and Planning Work Group was facilitated by Dr. Gerald Goodenough. Key recommendations made were to:

a. establish national policy for geriatric and gerontological education,

b. incorporate education in different settings,

c. improve teaching and care of services to elderly persons,

d. determine how current research can be phased into the educational offerings,

e. address the issue of scarce allocation of resources,

f. emphasize recruitment of minority faculty and care of minority people,

g. influence career choices in elder care,

h. focus on special interest age groups such as the retarded and disabled who become elderly,

i. model the interrelationship of internal and family medicine and various other disciplines, and

j. facilitate GECs' relationship to professional organizations and societies.

Ms. Bernice Parlak of the Pennsylvania GEC and Dr. Patricia Blanchette of the Pacific Islands GEC were chosen as coordinators.

On the second morning, Saturday, 23 April, a business breakfast was held for exchange of information between center directors and federal officials. Thomas Hatch, Associate Administrator for Policy Coordination at HRSA, gave the plenary session address, "Issues in Geriatric Education." The remainder of Saturday morning was devoted to five GEC staff development sessions, brief summaries of which follow.

Group A: Strategies for Curriculum Integration, led by Dr. George Caranasos of the University of Florida GEC, concluded that one barrier to inclusion of sufficient geriatrics into the medical curriculum that must be overcome is the ramifications of inadvertently assuming that since geriatrics should be practiced well by each provider by discipline, it therefore does not devolve on any single group and suffers from lack of locus.

Group B: Interdisciplinary Education in Geriatrics, led by Dr. Benjamin Liptzin of the Harvard GEC, concluded that interdisciplinary education and service programs should be taught to health professions students via effective role models.

Group C: Recruitment and Retention of Minorities in Geriatrics, led by Dr. Rumaldo Juarez of the TCGEC, concluded that all GECs should incorporate minority recruitment and retention into evaluation protocols and include a cross-cultural emphasis for the Fifth Workshop.

Group D: Clinical Experiences as Part of Faculty Development, led by Dr. Jesley Ruff of the Midwest GEC, concluded that in developing clinical training experiences for clinical faculty, their varying degrees of experience must be taken into account.

Group E: Approaches to Resolving Unanticipated Problems, led by Dr. Robert Wallace of the Iowa GEC, concluded that no certain mechanism can handle all situations that arise unexpectedly other than having good communication between and among all participants.

An opportunity to share information regarding the educational, technical, and resource activities underway at each GEC occurred during the table clinic displays and in conjunction with a buffet luncheon on Saturday. Each center had the opportunity to display curricular and other materials, finished products, or illustrations of projects in progress to share with other centers. It was also during this time that Marion Laboratories sponsored a special presentation of geriatric videotapes. Mr. Audie Thor, Marion's Professional Educa tion Liaison, was available to display and discuss the various tapes. Saturday afternoon concluded with a plenary session panel discussion entitled, "The Role of GECs in Community Development." Ms. Linda Brasfield of the OVAR GEC facilitated this session along with Drs. David Haber, Eric Rankin, and Carlos Gonzalez Oppenheimer of Creighton Regional GEC, Great Lakes GEC, and GEC of Puerto Rico, respectively.

Sunday morning, 24 April, began with a meeting of the federal project officers with all GEC representatives. Drs. Gleich and Louden and Mr. Koenig were available for any questions and comments during this time. A brunch was held during which the closing plenary panel session, "Future Directions for Geriatric Education Centers," was held as the conclusion to this year's workshop: Dr. Evan Calkins of the Western New York GEC, Dr. John Beck from California GEC, Dr. Jerome Kowal of Case Western Reserve GEC, and Dr. Terry Fulmer, then of Columbia University, discussed the merits and necessity of such a national network. The major points raised during this closing plenary session were as follows: 1. through the approximately half decade of GECs existing nationally a point in time has been reached when a candid assessment needs to be made as to the future direction of the training of academic leaders in the various fields; 2. following five years of funding, GECs should have the opportunity to apply for an actual dollar-for-dollar matching-funds grant to continue operations; 3. the number of GECs needs to be stabilized to afford ongoing "centers of excellence"; and 4. GECs need to become institutionalized via local funding and through resource exchange mechanisms.

The Fourth GEC Workshop adjourned on Sunday, April 24, 1988 at noon following presentation of a certificate of appreciation signed by each GEC director or representative that was given to Dr. Carol Gleich in recognition of her fine work with the GEC movement. Dr. Gleich has accepted a new position as Chief of Resources Development Section, Division of Medicine, BHPr, HRSA.

III. SUMMARY REMARKS

Although begun in Buffalo, two major products emerged from the workshop: one, the transition from ad hoc task forces to four work groups should facilitate an ongoing forum for the mutual benefit of all GECs (this activity should be recognized and funded in some way, e.g., supplemental grants to the convening GEC); second, a standard format now exists with which all GEC educational activities can be recorded and summed across GECs. Use of the latter should assist in targeting some disciplines by numbers needed.

This executive summary acknowledged the numerous presenters and highlighted the major events and outcomes of the Fourth Workshop for Key Staff of GECs held in Houston, Texas April, 1988. A detailed account of this important gathering of national leaders in geriatric education can be found in two companion documents: a workshop final report sent to all attendees and an administrative report submitted to the federal project officer and the HRSA Contracts Office. It is hoped that these documents will serve to advance the further development of the GECs nationally.

FINAL REPORT

Fourth Workshop for Key Staff of
Geriatric Education Centers

Houston, Texas

April 21-24, 1988

Prepared by the Staff of

The Texas Consortium of Geriatric Education Centers

Baylor College of Medicine
Houston, Texas

The report was prepared in partial fulfillment of contract HRSA 240-87-0071 from the Bureau of Health Professions, Department of Health and Human Services. Any view expressed or statements made herein are those of the workshop presenters and/or staff editors and do not necessarily reflect the official position of the Health Resources and Services Administration or of the Bureau of Health Professions.

FOURTH GEC WORKSHOP FINAL REPORT

Section Page

I. Purpose of Workshop 1

II. Project Staff and Planning Committee Members 2

III. Workshop Agenda - Orientation kof New GECs and Session Summaries 3

IV. Workshop Agenda - Fourth kWorkshopfor Key Staff of GECs and Session Summaries 31

V. List of Registrants 88

I. PURPOSE OF WORKSHOP

The Fourth Workshop for Key Staff of Geriatric Education Centers (GECs) was held in Houston, Texas on April 21-24, 1988, under contract number HRSA 240-87-0071 from the Bureau of Health Prosessions, Department of Health and Human Services. The purpose of the contract was to design and conduct an effective workshop for representatives of the then thirty-one federally funded centers located throughout the nation. Specifically, the workshop was to provide an opportunity to explore issues affecting the educational, technical assistance and assessment roles of the GECs and to enable key staff from all centers to interact with one another, share strategies, and jointly consider national GEC purposes. In order to achieve these purposes, several objectives were formulated; it was envisioned that attendees would have the opportunity to engage in the following activities:

1. share developed curricula relating to diagnosis, treatment, and prevention of diseases and other health concerns of the elderly;
2. review those instructional methods used to prepare and strengthen key faculty in geriatrics and gerontology;
3. describe characteristics of project staff and trainees involved in the national GEC network and document the nature of their educational experiences in gerontology and geriatrics;
4. identify current offerings in geriatrics within the curricula for the various disciplines comprising GECs;
5. develop affiliations with other new and current GECs;
6. delineate potential opportunities for the advancement of geriatric education within each GEC's area or region; and
7. promote organizational arrangements and administrative entities which improve education in geriatrics.

II. PROJECT STAFF AND PLANNING COMMITTEE MEMBERS

The contractor for the Fourth Workshop was the Texas Consortium of Geriatric Education Centers (TCGEC), headquartered at the Center for Allied Health Professions, Baylor College of Medicine, Houston.

Project personnel included:

Name	Responsibility
Robert Roush, Ed.D., M.P.H.	Project Director
Carl E. Fasser, B.S., PA-C	Co-Project Director
Teresa L. Wright, M.P.H. candidate	Workshop Coordinator
Sherry McDonnell	Workshop Secretary

Project Officer from the Bureau of Health Professions:

Carol Gleich, Ph.D.	Bureau of Health Professions Project Officer

Secretarial and administrative support was provided to the project staff by **Mrs. Darla DiStefano, Mrs. Iris Cox, and Ms. Gwendolyn Simms.**

The project staff also benefited greatly from the expertise and insight of the following members of the Workshop Planning Committee:

John Feather, Ph.D.	Associate Director Western New York GEC
Linda Brasfield, M.S.	Director OVAR GEC
Michele Saunders, D.M.D., M.S., M.P.H.	Director South Texas GEC
Itamar Abrass, M.D.	Director Northwest GEC
Eric Pfeiffer, M.D.	Director University of South Florida GEC
James O'Brien, M.D.	Director GEC of Michigan

III. WORKSHOP AGENDA

Orientation of New GECs

and

Session Summaries

Thursday, April 21, 1988 - Orientation of Nine GECs

		LOCATION
11:30 AM -1:00 PM	REGISTRATION	
1:00 PM	WELCOME, INTRODUCTIONS AND REVIEW OF PURPOSES Robert Roush, Ed.D., M.P.H., Project Director, Texas Consortium of Geriatric Education Centers (TCGEC) Carol Gleich, Ph.D., Project Officer, Fourth Workshop for Key Staff of GECs	Sequoia
1:15 PM	FEDERAL PERSPECTIVE OF NATIONAL GEC PROGRAM Thomas Louden, D.D.S., Director, Division of Associated and Dental Health Professions, Bureau of Health Professions, HRSA	Sequoia
1:45 PM	MANAGEMENT OF GERIATRIC EDUCATION CENTERS **Role of Grants Management** John Westcott, M.P.H., Grants Management Officer **Role of Project Officer** William Koenig, M.P.A., Deputy Chief, Associated and Dental Health Professions Branch **Coordination Among GECs** Carol Gleich, Ph.D., Coordinator, GEC Grant Program	Sequoia
2:45 PM	IDEA EXCHANGE SESSION/COFFEE BREAK	
3:00 PM	PROGRAM DEVELOPMENT Michele Saunders, DMD, MS, MPH*, *South Texas GEC* John Feather, Ph.D., *Western New York GEC* Jodi Teitelman, Ph.D., *Virginia Commonwealth GEC*	Sequoia
4:00 PM	EVALUATION STRATEGIES Jurgis Karuza, Ph.D.*, *Western New York GEC* Richard Hubbard, Ph.D., *Western Reserve GEC* Lucia Torian, Ph.D., *Hunter/Mt. Sinai GEC*	Sequoia
5:00 PM	EVALUATION OF SESSION Carl Fasser, P.A.-C., *TCGEC*	Sequoia
5:15 PM	INDIVIDUAL STUDY	
7:00 PM	NEWCOMERS' RECEPTION AND DINNER Guest Speaker, John Wolf, M.D. Chairman, Department of Dermatology Baylor College of Medicine	Forest (4 & 5)

Friday, April 22, 1988

		LOCATION
7:45-8:30 AM	CONTINENTAL BREAKFAST	Forest
8:30-10:00 AM	GEC STAFF DEVELOPMENT SESSION	
	Group A: Models in Geriatric Education: Impressions and Concerns Joyce Prothero, Ph.D.*, *Northwest GEC* Lynn Groth, M.S., *Dakota Plains GEC* Elizabeth Sanchez, Ph.D., *Univ. of Puerto Rico GEC*	Camelia
	Group B: Strategies to Promote Education in Geriatrics J. Richard Connelly, Ph.D.*, *Intermountain West GEC* Bernice Parlak, M.S.W., *GEC of Pennsylvania* Gary Nelson, D.S.W., *Univ. of North Carolina at Chapel Hill GEC*	Magnolia
10:00 AM	IDEA EXCHANGE SESSION/COFFEE BREAK	
10:15 AM	GEC TECHNICAL ASSISTANCE SESSIONS	
	Group A: Accessing Educational Resources Linda Davis, MPH, PhD, OTR*, *Pacific GEC* Joanna Mellor, M.S., *Hunter/Mt. Sinai GEC* Davis Gardner, M.A., *OVAR GEC*	Magnolia
	Group B: Establishing Community Linkages Carolyn Marshall, M.P.H.*, *South Texas GEC* Richardson Noback, M.D., *Missouri GEC* Ames Tyron, D.D.S., Ph.D., *Mississippi GEC*	Willow
11:45 AM	EVALUATION OF SESSION Carl Fasser, P.A.-C., *TCGEC*	Sequoia
12:00 NOON	ADJOURN (Lunch by Individual Arrangement)	

* Facilitator

ORIENTATION OF NINE NEW GECs

Title: WELCOME, INTRODUCTIONS AND REVIEW OF PURPOSES

Presenter(s): Robert E. Roush, Ed.D., M.P.H., Project Director, TCGEC

Carol Gleich, Ph.D., Project Officer, Fourth Workshop for Key Staff of GECs

Following the welcome, three distinguished governmental colleagues from the Bureau of Health Professions were introduced; they were Dr. Tom Louden, head of the division that funds the geriatric education centers; Dr. Carol Gleich, Project Officer for the Fourth Workshop and the person responsible for oversight of the GECs; and Chief, Geriatric Education Section, Division of Associated and Dental Health Professions, Mr. Bill Koenig.

A planning committee, together with the Baylor College of Medicine staff,designed the workshop: Members recognized were Dr. Itamar Abrass from the Northwest GEC, Mrs. Linda Brasfield from the OVAR GEC, Dr. John Feather from the Western New York GEC, Dr. James O'Brien from the GEC of Michigan, Dr. Eric Pfeiffer from the University of South Florida GEC, and Dr. Michele Saunders from the South Texas GEC. The planning committee represented a mix of directors of new GECs and from those that have existed for three to five years so that input from both groups could be obtained.

The one-day orientation was a new feature of this workshop so the nine new GECs could become acquainted with existing GECs and with each other. The program was also designed to have the older GECs share experiences they've had, both good and bad on these topics: designing staff development and strategies to promote education in geriatrics, accessing existing educational resources and establishing community linkages.

As a meeting of the nation's top geriatric educators across the health professions, this Fourth Workshop was designed to provide the Bureau the opportunity to gain insight into the roles GECs play in their institutions.

III. SESSION SUMMARIES

Title: FEDERAL PERSPECTIVE OF NATIONAL GEC PROGRAM

Presenter(s): Thomas Louden, D.D.S., Director, Division of Associated and Dental Health Professions, Bureau of Health Professions, HRSA
Carol Gleich, Ph.D., Project Officer, Fourth Workshop for Key Staff of GECs

Dr. Louden congratulated all present on being members of an elite group of geriatric educators, inasmuch as they were selected as members of the HRSA GEC group.

Other people in the division--program officers Mr. Don Blanford, Dr. Frank Martin and Ms. Doris Droke and Mr. John R. Westcott, our grants management officer--were to have attended. Instead, Mr. Bill Koenig spoke in place of the grants management officer.

Dr. Louden discussed the organizational chart of the Public Health Service: The parent agency, Health Resources and Services Administration, with 2,300 employees and a budget of $1.6 billion, is responsible for Title VII and Title VIII of the Public Health Service Act: Title VIII deals with the training of nurses while Title VII deals with the training of all other health care providers. To carry out these functions, the Bureau has five program divisions: Division of Medicine, Division of Nursing, Division of Student Assistance, Division of Disadvantaged Assistance, and the Division of Associated Dental Health Professions in which the GECs are housed.

Activities carried out in the training authorities specific to geriatrics and gerontological education fall into two programs. They are the geriatric education center program and the new geriatric training and fellowship program.

Acting as regional resources to provide multidisciplinary geriatric training for health professions faculty, students and practitioners, 31 geriatric education centers are now in 24 states and Puerto Rico. Under 788E, the secretary may make grants to and enter into contracts with schools of medicine,

schools of osteopathy, teaching hospitals, and graduate medical education programs for the purposes of providing support, including traineeships and fellowships for geriatric medicine training projects that train physicians and dentists who plan to teach geriatric medicine or geriatric dentistry. Under this section of the law, a subsection stipulates that participants in a project be exposed to a diverse population of elderly individuals and provide training in geriatrics, including problems of mentation, through a variety of service rotations such as geriatric consultation services, acute care programs, rehabilitation services, extended care facilities, geriatric ambulatory care and comprehensive evaluation units, and community care programs for the elderly mentally retarded individuals. The training options are either a one-year retraining program in geriatrics or a one or two-year internal medicine or family medicine fellowship program which emphasizes training in clinical geriatrics and geriatric research.
Another category of the Bureau of Health Professions' geriatric education activities includes geriatric training that occurs as a part of more broadly focused primary care, dental, nursing or other grant programs. Some examples would be allowing or encouraging development of geriatric curriculum elements as a part of a physician assistants training program or part of an area health education center program or preventive medicine residency training program. The division of nursing has a large number of activities in geriatric education.

In the Division of Medicine, a recently finished contract consists of five competency-based modules covering hospitals, ambulatory site, nursing home, rehabilitation, and complete evaluation of geriatric education including the study jointly conducted with the American Academy of Physician Assistants in which nine different geriatric sites were visited to observe the role of physician assistants (PAs).

The Dental Health Branch supports the post-doctoral training of dentists with the general goal on preparing them to deal better with the elderly population. Another thing that the Division of Associated Dental and Health Professions has supported in the past are national conferences on geriatric education. The first conference in 1985 was held in Washington; 300 people attended the conference titled, "Issues and Strategies for Geriatric Education." Over 400 people attended the second conference in 1986, "Geriatric Education - New

Knowledge, New Settings, New Curriculum." The planning for a third conference, to be held in December in 1988, is underway: the theme is going to be "Rehabilitation Aging and Geriatric Education" and will be jointly sponsored by the National Institutes of Aging and The University of Pennsylvania.

Another area of HRSA Bureau activity in partnership with the National Institute on Aging is membership of the government-wide forum on aging-related statistics. The Bureau of Health Professions also has many liaison activities with other federal institutions. One of the more prominent ones is the DHHS Committee on Education and Training in Geriatrics and Gerontology which the Director of the National Institute on Aging, Dr. Williams, chairs; the former Director of the Bureau of Health Professions, Mr. Hatch, acted as a liaison member. That committee produced the 1984 report on education and training in geriatrics and gerontology and the recent report entitled Personnel for Health Needs of the Elderly Through the Year 2020.

Based on a congressional directive, the first HRSA grants for GECs were made in 1983; about one million dollars were awarded to four centers. That program has grown to the current appropriation of $10 million dollars.

Dr. Gleich then continued the orientation with an extensive description and slide show chronicling the development of the first four GECs at the University of Michigan, Harvard, SUNY Buffalo, and University of Southern Cal, now referred to as the "four-fathers." Dr. Gleich stated that there wasn't a grant in 1984 cycle; however, one million dollars went for the four continuation grants. In 1985, sufficient congressional appropriations resulted in a group now called the "sweet sixteen" being funded. By the end of 1987, 31 projects from Hawaii to Puerto Rico had been funded.

Title: MANAGEMENT OF GERIATRIC EDUCATION CENTERS (GECs)

Role of Grants Management

Objective(s):

- Describe oversight responsibility of the grants management officer.
- Review mechanisms guiding changes within approved budgets, especially institutional prior approval processes.
- Comment on regulations governing reports and the retention of records and documents.

Role of Project Officer

Objective(s):

- Describe oversight responsibilities of the project officer.
- Discuss ways to facilitate periodic communication of center activities.

Coordination Among GECs

Objective(s):

- Describe mechanisms for the coordination of information on center activities.
- Discuss ways to facilitate inter-center communications.

Presenter(s): Thomas Louden, D.D.S., Director, Division of Associated and Dental Health Professions, Bureau of Health Professions, HRSA

Carol Gleich, Ph.D., Project Officer, Fourth Workshop for Key Staff of GECs

William Koenig, M.P.A., Chief, Geriatric Education Section, Division of Associated and Dental Health Professions

Drs. Louden and Gleich made introductory remarks followed by those of Mr. Koenig's.

Mr. Koenig described the Public Health Service document, DHHS Publication No. OASH-82-50000 dated January 1987, which covers freedom of information, allowable use of different kinds of costs, the basic ground rules for peer review, staff review, award process, etc. The document also describes grantees' responsibilities in terms of using federal money. This document is present in every university business office; in it is a description of a grants management office which, in the case of Bureau of Health Professions, is headed by Mr. John R. Westcott. Assisting Mr. Westcott is Ms. Judy Bowen. The awarding office grants management officer is also the official authorized to make the decision on requests for any changes in terms of the award. Regardless of opinions expressed by program officers, fundamental changes in the project scope and use of money aren't official unless confirmed in writing from Mr. Westcott.

Title: PROGRAM DEVELOPMENT

Objective(s):

- Describe mechanisms used to ascertain need for programs offered at the regional, state, and inter-state levels.
- Discuss strategies devised to implement programmatic activities at the regional, state, and inter-state level.
- Comment about types of problems encountered since the implementation of center activities.

Presenter(s): Michele Saunders, DMD, MS, MPH, South Texas GEC
John Feather, Ph.D., Western New York GEC
Jodi Teitelman, Ph.D., Virginia Commonwealth GEC

Dr. Michele Saunders made a suggestion that becoming adopted by one of the older GECs can help in avoiding some of the mistakes new GECs usually make in organizing and implementing their training programs in the first year.

The chief objective addressed through this session was ascertaining needs for programs within regional, state, and interstate levels. The South Texas GEC's experience in this area was recounted inasmuch as its service area is a 62-county region larger than New York, New England, New Jersey, Delaware, Maryland, and Pennsylvania.

A handout was distributed that illustrated a needs assessment instrument that gathered data from service chiefs and other faculty on what they were doing vis-a-vis the GECs. These data generated a tremendous number of collaborative research efforts and educational projects that came about simply because of something as simple as a questionnaire circulated to the faculty. In constructing and field-testing the instrument, much was learned about cultural biases that resulted in preventing development of a questionnaire that wasn't specific for Hispanics.

The second page of the South Texas GEC instrument was for a community survey. One side is in English; the other side is in "Tex-Mex" Spanish.

Another survey was sent to numerous community organizations dealing with the elderly; the results were a number of interesting comments that revealed what people really needed, e.g., diabetes is epidemic among the Hispanic population in Texas. In concentrating on this disease, it was discovered that within the state of Texas there is an absolute dearth of educational materials for either the illiterate of either language or the very low-educated of either language. The American Diabetes Association produced a bilingual pamphlet, but few could read it because it's written at the college level and with no pictures.

The next survey was for nursing home administrators. Nursing home administrators constitute a large resource for GECs who have trouble finding other interested community practitioners. With inordinately high annual turnover rates for nursing home aides who have very little training, one of the things felt to be important was to work with nursing home administrators to convince them that these aides needed to be trained.

The last questionnaire was the Winter Texas Survey. Unique to the Sunbelt is the whole group of middle Western elderly persons estimated at about two hundred and fifty thousand who come to the Rio Grande Valley of Texas for up to six to nine months of the year for the pleasant weather. Questions to which answers were sought were as follows: "Were these people bringing their medical records? Did they use the health facilities? What was this doing to the health care provider and what was it doing to the Hispanic population? Were they still being seen or not?" It was not known whether these winter Texans called "snow birds" used the public health clinics; indeed, they were, and it was putting a strain on the public health clinics which were staffed year round based on summer population levels, not at the swollen winter population levels. What was found to be happening is that the Hispanic population then received less care for six months a year.

Dr. Teitelman addressed the issue of being funded and immediately having to implement the provisions of the grant.

Since each GEC has the same mission, i.e., quality education and training in geriatrics and ultimately quality care of older patients, GECs were encouraged to identify resources, the principal strengths and unique characteristics of their institutions; continue evolving by looking at other institutions and branching out into the community; and to build GEC programs around the unique strength of the respective institutions. If one looks at successful GECs, the models and structure of the programs vary; yet all are accomplishing the same goals and objectives.

Virginia Commonwealth University noticed that they already had an excellent training program in place for medical interns and residents and for other health professional disciplines at the VA center; rather than duplicate effort, the program at the VA was used as the primary training site for the faculty development program. Also at the time VCU was initially funded, people in the office of media instruction were very interested in expanding telecommunications at the university and were actively looking for a vehicle to promote the effectiveness of telecommunications as an educational vehicle. This affiliation resulted in ten national broadcasts of teleconferences on a variety of geriatric-specific topics.

Dr. Feather shared some observations from having looked at a lot of GECs based on his training as an organizational sociologist. A number of GEC grants are structured in such a way that numerous people with less than fifteen percent of their time are tied up in the budget. While that staffing pattern can be made to work, structurally one could experience trouble. GECs are a peculiar kind of organization because not enough money from the government is awarded to actually run a lot of programs. One must pull together things that are already in existence; thus, GECs become an even more fragmented type of organization. After a year, one may decide to make some choices in reorganizing the GEC.

Another problem observed for some of the GECs is getting so involved in program operations that not enough time is spent in communication. Whether one thinks of this as marketing or interfacing or whatever, this should be a major part of a GEC's overall effort. Communicate with the community, with the university, and keep in touch with the bureau staff as well as with the other GECs.

The third point made focused on the goal of professional faculty training. Regardless of varying methods, one doesn't have very much money to work with. Thus, it was recommended that one identify other institutional resources and put packages together in a way that helps in attaining goals.

Title: EVALUATION STRATEGIES

Objective(s):

- **Provide historical perspective of steps taken to evaluate faculty development activities.**
- **Discuss factors considered when constructing protocol for evaluation of center activities.**
- **Indicate ways in which information obtained through evaluation has refined specific center activities.**
- **Engage participants in discussion of issues surrounding the collection and analysis of information regarding center activities.**

Presenter(s): **Jurgis Karuza, Ph.D., Western New York GEC**
Richard Hubbard, Ph.D., Western Reserve GEC
Lucia Torian, Ph.D., Hunter/Mt.Sinai GEC

Dr. Karuza pointed out that as objectives change, evaluation strategies should change. The evaluation process can be very coercive in helping map changes and objectives, thus leading to individualized evaluation approaches.

Evaluation tools are nothing more or less than practical instruments for the GECs. Evaluations can also be helpful in planning new objectives. The evaluation tool is a more scientific, objective way of getting information about where the GEC should be going two years, three years, five years down the line.

A long-term issue on which attention should be focused is the feasibility of standardizing evaluation instruments.

Dr. Hubbard stated that the goal of the evaluation task force begun in Buffalo last year was to come up with a strategy that provided enough flexibility for each GEC's personality to show, but at the same time at least use the same language.

The first common denominator GECs came up with was a forty-hour training package, whether clinical in nature, a series of workshops, or one week-long institute. Enrollees were envisioned as people committed to a program of training of at least forty hours.

The second issue concerned who was being trained. Seven trainee categories were developed: (1) Academic faculty; (2) Clinical faculty were separated out for a reason--first, the kinds of educational skills they need are not how to give a lecture, but how to supervise a student and how to give feedback in a clinical setting; (3) In-service and continuing education coordinators and health educators are people who are primarily in practitioner settings, but who have educational responsibilities; (4) Administrators generally come in for training because they are planning a new geriatrics program; (5) Practitioners in clinical practice can gain confidence as they become clinically more competent in dealing with the elderly; (6) Students; and (7) Lay persons.

In describing the recording instrument, the first column was for enrollees. The other areas broken down were the actual activities that GECs do, which were as follows: (1) Didactic presentations--lectures, conferences, mini-courses, and independent study programs--constituted the typical classroom category; (2) Clinical training included providing preceptorships, practicums, field placement, and mini-residences. This category was for more observational or participatory learning; and (3) Special projects, i.e., after one reached the forty-hour training level, called for enrollees to finish a "capstone experience," which involved taking what had been learned and applying it in one's area of responsibility, such as developing a course, a curriculum project, etc.

What was produced is a chart of disciplines by category of enrollee. Case Western also used an enrollee tracking form. The results of using this system afforded the Bureau of Health Professions an opportunity to collapse across GECs and determine that X number of academic faculty in medicine have been trained with the average number of enrollees per GEC.

Dr. Torian presented main components of evaluations that can improve GEC programs. The first thing to be done was a needs assessment before training begins. Enrollees were questioned to find out (1) what kind of geriatric training they've had in social work, medicine, and nursing; (2) what kind of geriatric population their institution served; and (3) what their perceived needs were.

Regarding impact and outcome measures, it was realized that to evaluate a number of different parameters perceived to be deficient in geriatric care would be difficult. However teaching GEC associates to do that themselves is important because conducting controlled studies of whether a training program that addresses whether certain special issues could actually make a difference in that institution is beyond the scope of the project.

What was being attempted was increase the quality of their commitment and increase their knowledge base and their expertise; thus, they learned how to do cognitive testing, evaluations, and how to do a study of whether one nursing unit can actually prevent falls or whether the physicians can deal with polypharmacy over a short period of time.

The final thing was the crucial nature of follow-up. Except for needs assessment, follow-up consisting of six-week surveys, six-month surveys, telephone hotlines, follow-up workshops, and colloquia that involved both former and current associates revealed more than anything. Follow-up was critical for curriculum development for restructuring the organization and for being able to respond to the needs of the population.

Finally, institutions inadvertently place a lot of obstacles in the way of faculty associates who go back and try to implement GEC programs. It may just be a question of release time or it may just be a question of overcommitment for the staff. So one should try to identify where blocking occurs, why it's happening, what can be done about it, and how one can adjust for it in the future.

Title: GEC STAFF DEVELOPMENT SESSION

Group A: Models in Geriatric Education: Impressions and Concerns

Objective(s):

- Provide overview of varying approaches to the education of health professionals used by GECs.
- Discuss factors in choosing one strategy versus another.
- Identify perceived concerns in documenting the impact of one strategy versus another.

Presenter(s): Joyce Prothero, Ph.D., Northwest GEC, facilitator
Lynn Groth, M.S., Dakota Plains GEC
Elizabeth Sanchez, Ph.D., Univ. of Puerto Rico GEC

Dr. Joyce Prothero stated the Northwest Geriatric Education Center at the University of Washington in Seattle serves the states of Washington, Alaska, Montana and Idaho which comprise roughly 22 percent of the total land mass of the United States. The GEC involves seven units within the health science center comprised of the schools of dentistry, medicine, nursing, pharmacy, public health and community medicine; social work and the Institute on Aging at the University of Washington. The primary goal of the Northwest GEC is to make available instructional resources for the purpose of enhancing the knowledge, clinical skills, and teaching expertise of faculty and practitioners who teach or supervise students.

The principal training vehicle used is the Individualized In-Residence Traineeship which requires the completion of at least 80 contact hours of instruction during a one-year period. The traineeship may be completed on either a full-time or part-time basis on the University of Washington campus. Upon completion of the traineeship, each individual is expected to integrate the newly acquired content into their teaching or practice situations. The other mechanisms, outside of consultation and technical assistance, used to improve the geriatric knowledge of both practitioners and educators is an intensive, five-day summer institute.

Factors contributing to selection of the area served and the instructional programs offered included relationships established through the WAMI continuing education network, costs associated with moving faculty experts across a large geographic area, previous dealings with area health education centers within each of the four states, and the capabilities existing within the health science center.

Mr. Lynn Groth described the Dakota Plains Geriatric Education Center which serves a two-state area, specifically North Dakota and South Dakota State University and the University of South Dakota. The Department of Family Medicine within the UND School of Medicine in Grand Forks serves as home for the Dakota Plains GEC. The activities of the center are directed at assisting health professions educators and associated service providers to improve their teaching capabilities in geriatrics. A faculty of experts and an advisory committee comprised of various health professionals within the two-state region are used to assist the programmatic offerings of the center.

The primary mechanism used to improve geriatric education and practice within the health professions is the Fellowship Program. Over the course of a year, fellows chosen from the participating institutions are expected to complete three, one-week didactic seminars, develop curricula, pursue independent study in geriatrics, and complete a leadership project related to the needs of their respective institutions. Approached in this fashion, it was felt possible to have a longer lasting impact on the individual trained and the institutions involved.

Dr. Elizabeth Sanchez directs the Geriatric Education Center of the University of Puerto Rico which is part of the faculty of Biosocial Sciences and Graduate School of Public Health of the medical sciences campus. The center's goal is to improve the quality of health care services to the island's elderly population in ways that will assure adequate treatment of older individuals. The approach used to accomplish this goal involves the education of faculty in geriatrics who will, in turn, train future health care providers. Disciplines participating in the faculty training effort include medicine, nursing, allied health, dentistry, public health, pharmacy and social work.

A twelve-week program comprised of four formal courses is used to enhance faculty knowledge and skills in geriatrics. Consultative advice and technical assistance are provided to each faculty member by instructional design specialists when faculty trainees are ready to incorporate geriatric content into their school's curricula.

Irrespective of the approach to training health professions educators and community practitioners, methods exist by which to discern the numbers and disciplines involved. It is more difficult to discern the exact impact at the institutional or practice level. Of even greater concern is what effect does the departure of a trained individual have on the content within a specific course over time.

Group B: Strategies to Promote Education in Geriatrics

Objective(s):

- o Describe environment within institutions and surrounding community relative to education in geriatrics when preparing application for center grant.
- o Discuss how environment has changed over time since implementation of center activities.
- o Identify those steps taken which appear to have had the greatest impact on geriatric education in these environments.
- o Engage participants in discussion of alternative ways in which to engender greater interest in geriatric education.

Presenter(s): J. Richard Connelly, Ph.D., Intermountain West GEC, facilitator
Bernice Parlak, M.S.W., GEC of Pennsylvania
Gary Nelson, D.S.W., Univ. of North Carolina at Chapel Hill GEC

Richard Schulz, Ph.D. (for Ms. Parlak who was not present), Co-Director of the GEC of Pennsylvania presented his program in terms of its core components, history and changes. The program is based in eastern Pennsylvania at Temple University and the University of Pittsburgh on the western end of the state. Bernice Parlak, MSW, directs the program as a whole. As co-director at the University of Pittsburgh, two parallel programs which draw on the resources of both universities are conducted with a core faculty of about 20 individuals from all major disciplines. Temple is very strong in dentistry and pharmacy, so their dental and pharmacy faculty come to Pittsburgh to do training with medicine and vice versa. The core of the training program is a seven-day, sixty-hour intensive which runs consecutively; attendees must make a commitment to come to one of the campuses and stay there for seven full days.

Another feature is having students sign a contract before or when they enter the course. That contract specifies what they're going to do with what the GEC provided them after they complete the training session. Gloria Barry, Ph.D., project coordinator, is responsible for this.

The GEC was built upon a long-standing institute on aging at Temple focusing primarily on gerontologic research; decentralized activities, primarily in the health sciences area, are at Pittsburgh

Dr. Connelly from the University of Utah presented a different approach than that of Dr. Schulz. An aging network was formed to invite practitioners and Triple As of state units on aging plus the faculty in each of the state universities to come to a centralized location for an initial visit; it was a day-long didactic session with discipline-specific hourly meetings within that day so that every discipline had some time to interact. A continuing education session for each of the disciplines helped recruit practitioners. Clinical rounds were conducted in a local hospital or nursing home that were both discipline-specific and interdisciplinary at each of the sites. Staff went back three other times during the two years to each of those sites and carried out that same kind of agenda: a didactic day of education, a clinical rounding of disciplines leading to interdisciplinary rounds, and a continuing education session. Trainees were brought into Salt Lake for specific faculty development education.

The emphasis in the third year was bringing those selected faculty into Salt Lake City for two sessions. One was a four-day intensive designed to produce either modules or courses assisted by a librarian, a one-on-one session with a discipline-specific peer, and then a meeting with the remainder of the faculty to talk about issues that are interdisciplinary or multidisciplinary in nature. The second session was a one and a half-day intensive at which four guest speakers -- a geriatric nurse and a geriatric physical therapist -- addressed research as well as clinical issues.

One other thing done in the second year was enrollees team taught a geriatric lecture with their discipline peer. Trainees then solo teach and are given feedback about their presentations.

A question was asked about publications depicting GEC training. Dr. Connelly responded that at his GEC there exists a training manual that describes the sequence of courses or lectures as well as outlines for each.

Questions from audience: What philosophy or concepts were used to design your educational program? The response was that the initial assumption was that most of our people didn't know very much and so the first set of courses or lectures were very basic geriatric, gerontological material. We soon learned after the first visit with feedback on those discipline-specific sessions that we had a group of people who had a lot more expertise than we had assumed and wanted very specific things on disease and illness, long-term care, service delivery, and problems in networking.

A comment from the audience was use of a "topic approach" coupled with an analysis of the literature in the specific disciplines tying that literature to the competencies that are required in each discipline and then comparing the competencies with curriculum guidelines. Then a monthly series was held in which people from various disciplines looked at the competencies and had an interdisciplinary exchange.

Dr. Nelson commented that Ms. Linda Redford at the University of Kansas' Medical Center and Nursing School has an Administration on Aging grant to gather curriculum in the health and allied health schools. To be published in June 1988, this work would be another source for many to use as curriculum guides.

TITLE: GEC TECHNICAL ASSISTANCE SESSIONS

Group A: Accessing Educational Resources

Objective(s):

- Discuss repositories of information available to faculty responsible for educational programs for care providers.
- Review mechanisms used by various groups to evaluate quality and appropriateness of resources as educational tools.
- Describe materials development activities underway within existing GECs.
- Engage participants in discussion concerning perceived needs for instructional resources for target populations.

Presenter(s): Linda Davis, M.P.H., Ph.D., O.T.R., Pacific GEC
Joanna Mellor, M.S., Hunter/Mt. Sinai GEC
Davis Gardner, M.A., OVAR GEC

Ms. Linda Davis, Ms. Joanna Mellor, and Ms. Davis Gardner each contributed to the following summary of this sesson.

Early on it was necessary to undertake the collection and classification of large volumes of materials as a means of discerning both what was available and its value to activities undertaken by geriatric education centers. Early years at the Pacific GEC focused on the development of a comprehensive repository of aging-related materials. Library holdings were reviewed, adult education resources identified, clearinghouse bibliographies and materials obtained, professional associations contacted, expert faculty and practitioners recruited and developers of textbooks and audiovisuals contacted. As a result of these efforts, it was possible to identify standards of practice in geriatrics adopted by professional organizations, generate content outlines for use with curriculum development activities, prepare discipline-specific bibliographies for use in association with GEC-sponsored programs, and establish a resource network throughout region nine comprised of educators, publishers and clearinghouses. By contrast, the informational activities engaged in by the Hunter/Mt. Sinai GEC were centered around providing technical support services and folders of materials germane to programmatic activities without building another library or for that matter a comprehensive resource center. Factors contributing to the decision included the number of libraries already available and the fact that most disciplines had their own list of resources for information. Whatever the approach taken relative to GEC program attendees, it was clear that considerable information already existed; and if used wisely, should meet the needs of most health professionals. The mechanisms used to evaluate the quality of available educational materials have involved formal critiques in form of accuracy, newness, usefulness and level of appropriateness to informal feedback regarding content from faculty experts in the field. Unique approaches have also included faculty-sponsored journal clubs and audiovisual festivals run annually using program associates. The outgrowth of these kinds of activities was an awareness of the importance of content experts when selecting materials for program attendees, and that instructional resources less appropriate to the needs of faculty trainees were however, usable with paraprofessionals and volunteers.

The bigger questions relate to whether the information provided served to motivate program participants, met the informational needs of organizational representatives, and brought new information to health professionals interested in geriatrics. Experiences at some centers indicate that data gathered from participants in course offerings concerning the newness of information may be misleading. Long-term follow-up suggests that respondents were initially reluctant to acknowledge the newness of the information presented.

There are a number of existing projects being undertaken by individual centers. These projects include curriculum development guidelines, audiovisual catalogs, electronic bulletin boards and computerized bibliographic references. Other centers are focusing efforts on the preparation of syllabi for use with interdisciplinary learning programs, generation of care-based material for teaching activities, and content outlines for core programs. Many of these topics were discussed in an issue of Gerontology and Geriatric Education, (Vol. 8, Nos.3/4, 1988).

The above notwithstanding, it was also apparent that essential resources were lacking in such areas as bibliographic references on Hispanic elderly, minority faculty recruitment, and cross-cultural issues in aging. Another area to be considered involves preparation of a compendium of nationwide resources for funding training in gerontology. Lastly, resources to support the evolving review programs in geriatrics for internists and family physicians seeking credentialing as geriatricians should be widely available.

Group B: Establishing Community Linkages

Objective(s):

- Consider the purposes for which linkages are established with community agencies and organizations.
- Discuss the various mechanisms used to identify the nature of the linkage established.
- Explore the implications of community linkages to the scope of the educational programs and technical assistance activities offered by the center.
- Engage participants in a discussion of strategies to address factors perceived as impacting on the ability to establish essential linkages.

Presenter(s): Carolyn Marshall, M.P.H., South Texas GEC
Richardson Noback, M.D., Missouri GEC
Ames Tryon, D.D.S., Ph.D., Mississippi GEC

Ms. Carolyn Marshall, Dr. Richardson Noback, and Dr. Ames Tryon, each contributed to the following summary of this session.

Outreach activities within the community, whether the environment be the institutional campus(es) or the city or state surrounding a geriatric education center, were motivated by somewhat selfish purposes. For some centers the motivating factor stemmed from the need to identify physicians and other health professionals to participate in the educational programs offered. While it was initially possible to have a center serve the needs of the sponsoring institution's faculty, it rapidly became apparent that there existed a core of individuals from which to draw participants. Other centers viewed outreach activities within the community as a marketing tool designed to provide the visibility required to heighten consumer interest in the products and technical services available. Establishing linkages with professional groups, state advisory bodies, and campus representatives provided visibility for those activities underway. Through such contact and interactions one likewise acquired assistance with further access into the community, especially as it related to key players and community leaders. Such linkages also brought unexpected returns when technical assistance provided results in benefits to the community, an example being input to the design of a retirement community that resulted in a training site for health professions students. Lastly, some centers have used community linkages as mechanisms to facilitate continued institutional input to the development of potential solutions to problems. Through these networks one establishes the utility of center activities in the eyes of community leaders, legislative representatives, and key individuals in academic health centers.

The process by which one goes about the establishment and nourishment of linkages between geriatric education centers, local and state agencies, and health professions organizations, requires considerable attention. Outreach necessitates a certain conceptual framework within which to shape one's activities. It requires the use of communicators with proven abilities to acknowledge authority and follow through on commitment. These individuals must have demonstrated the ability to get all campuses into the community. Next is the strategy used to involve community representatives in the identification of perceived problems as opposed to perceived needs. Approached in this fashion, it allows the institution/geriatric education center to propose solutions to address the perceived problems and work with groups to select the most acceptable solutions and then establish project priorities. Simultaneously, one develops a reputation of being trustworthy, a reputation that then allows the center to bring its activities into communities.

As one sets about to establish community linkages, attention must likewise be paid to the extent of preexisting institutional involvement in community affairs, the existence of university-community linkages established through such mechanisms as extension services for agricultural and other purposes. In some states senior, full-time persons coordinate the communication and activities associated with their component of the network. With their assistance it is often possible to begin dialogue with community leaders essential to the identification of perceived problems. It is apparent that geriatric education centers have offered programs that were poorly attended as a result of inattention to community needs, as well as misperceptions regarding factors contributing to attendance. An example presented dealt with the absence of prior involvement in other community activities that translated to nonattendance.

The main implication of the lessons learned during the establishment of community linkages was that continued success, as evidenced by participation in programs over time, required ongoing involvement and attention to community-perceived problems. One must understand that faculty at community colleges and four-year colleges know how to teach and evaluate; whereas their interests evolved around content and resources to augment curriculum activities. One must also be aware that trust is established over time. An institution with limited prior community involvement cannot expect open acceptance overnight. The trust has to be earned over time through a demonstrated level of involved participation and follow-through.

Having established the ability to work within the community, it became necessary to develop inducements to participate. The marketing approaches developed across the country by geriatric education centers involved affiliation networks to access center resources and programs, award programs to recognize various levels of involvement in activities offered, and educational contracts to describe the things to be accomplished by persons enrolling in some form of professional development program. The professional development awards programs devised by the Mississippi GEC is perhaps the most notable example. In working with institutions to bring about curriculum change, the existence of national standards for a specific health-related discipline could be used to emphasize need for changes. This could be accomplished by comparing the standards with the results of an in-depth curriculum analysis. This same approach would then be carried over to program planning with state agencies dealing with credentialing of health care providers in nursing homes.

IV. WORKSHOP AGENDA

Fourth Workshop For Key Staff of GECs
and
Session Summaries

Friday, April 22, 1988

		LOCATION
11:30 AM -1:00 PM	REGISTRATION	Juniper
1:00 PM	OPENING REMARKS Michael E. DeBakey, M.D. Chancellor, Baylor College of Medicine WELCOME AND STATEMENT OF PURPOSES Robert Roush, Ed.D., M.P.H., Project Director, Texas Consortium of Geriatric Education Centers (TCGEC) Thomas Louden, D.D.S., Director, Division of Associated and Dental Health Professions Carol Gleich, Ph.D., Project Officer, Fourth Workshop for Key Staff of GECs	Juniper
1:15 PM	PLENARY SESSION ADDRESS **"Relationship of Geriatric Education to Service Delivery Models"** Itamar Abrass, M.D., *Northwest GEC* **Panel Discussion** Glen Hughes, M.D.*, *Univ. of Alabama GEC* Margaret Dimond, R.N., Ph.D., *Intermountain West GEC* Robert Luchi, M.D., *TCGEC*	Juniper
2:00 PM	TASK FORCE REPORTS TO PLENARY SESSION **Linkage Building:** Michele Saunders, D.M.D., M.S., M.P.H., *South Texas GEC* **Evaluation:** Jurgis Karuza, Ph.D., *Western New York GEC* **Curriculum:** Davis Gardner, M.A., *Ohio Valley Appalachia GEC* **Issues and Trends:** Bernice Parlak, M.S.W., *GEC of Pennsylvania*	Juniper
2:45 PM	COFFEE BREAK	Juniper

		LOCATION
3:00 PM	TRANSITION OF TASK FORCES TO WORK GROUPS	
	Group A: Linkage and Communication Work Group Recorder: George Magner, Ph.D., *TCGEC* Facilitator: Gloria Barry, R.N., Ph.D., *GEC of Pennsylvania*	Camelia
	Group B: Project Assessment Work Group Recorder: Ted Sparling, Dr.P.H., *TCGEC* Facilitator: Deborah Simpson, Ph.D., *Midwest GEC*	Magnolia
	Group C: Geriatric Education Work Group Recorder: Lisa Leonard, Ph.D., *TCGEC* Facilitator: Lucille Nahemow, Ph.D., *Univ. of Connecticut GEC*	Sequoia
	Group D: Policy and Planning Work Group Recorder: Otto Van Duyn, Ph.D., *TCGEC* Facilitator: Gerald Goodenough, M.D., *Intermountain West GEC*	Willow
4:15 PM	WORK GROUP REPORTS AND RECOMMENDATIONS	Juniper
4:45 PM	EVALUATION OF SESSION Carl Fasser, P.A.-C., *TCGEC*	Juniper
5:00 PM	INDIVIDUAL STUDY	
7:00 PM	WELCOME RECEPTION AND DINNER Weber Plaza, Texas Medical Center	

Saturday, April 23, 1988

		LOCATION
8:00 AM	BUSINESS BREAKFAST FOR GEC DIRECTORS WITH FEDERAL OFFICIALS	Forest (5)
8:30 AM	Continental Breakfast for Workshop Participants	Forest (1 & 2)
9:00 AM	PLENARY SESSION ADDRESS: **"Issues in Geriatric Education"** David N. Sundwall, M.D., Assistant Surgeon General and Administrator, Health Resources and Services Administration **Panel Discussion** Richard Besdine, M.D.*, *Univ. of Connecticut GEC* Rose DoBrof, D.S.W., *Hunter/Mt. Sinai GEC* Eric Pfeiffer, M.D., *Univ. of South Florida GEC*	Juniper
10:30 AM	IDEA EXCHANGE SESSION/COFFEE BREAK	Juniper

		LOCATION
10:30 AM	Set-up for Table Clinics **	Evergreen (1 & 2)
10:45 AM	GEC STAFF DEVELOPMENT SESSIONS	
	Group A: Strategies for Curriculum Integration George Caranasos, M.D.*, *Univ. of Florida GEC* Mark Stratton, Pharm.D.. *New Mexico GEC* Rosemary Orgren, Ph.D., *California GEC*	Camelia
	Group B: Interdisciplinary Education in Geriatrics Benjamin Liptzin, M.D.*, *Harvard GEC* Mary Ann Hilker, Ph.D., *Univ. of Florida GEC* Nancy Ellis, Ph.D., O.T.R., *Delaware Valley GEC*	Magnolia
	Group C: Recruitment and Retention of Minorities in Geriatrics Rumaldo Juarez, Ph.D.*, *TCGEC* Gwen Yeo, Ph.D., *Stanford GEC* Madeleine Goodman, Ph.D., *Pacific Islands GEC*	Sequoia
	Group D: Clinical Experiences as Part of Faculty Development Jesley Ruff, D.D.S.*, *Midwest GEC* Pat Blanchette, M.D., *Pacific Islands GEC* James O'Brien, M.D., *GEC of Michigan*	Willow
	Group E: Approaches to Resolving Unanticipated Problems Robert Wallace, M.D.*, *Iowa GEC* Elizabeth King, Ph.D., *GEC of Michigan* Barbara Palmisano, M.A., R.N., *Western Reserve GEC*	Aspen
11:45 AM	EVALUATION OF SESSION Carl Fasser, P.A.-C., *TCGEC*	Juniper
12:00 NOON	**Table Clinics *** and Buffet Luncheon**	Evergreen (1 & 2)
1:30 PM	GROUP REPORTS TO PLENARY SESSION Group A: George Caranasos, M.D., *Univ. of Florida GEC* Group B: Benjamin Liptzin, M.D., *Harvard GEC* Group C: Rumaldo Juarez, Ph.D., *TCGEC* Group D: Jesley Ruff, D.D.S., *Midwest GEC* Group E: Robert Wallace, M.D., *Iowa GEC*	Juniper

---

* Facilitator

** Each GEC will be provided a table on which they can display products, e.g., curriculum guides, newsletters, brochures, etc., that represent the activities of their center.

*** Special presentation of geriatric videotapes made possible through an educational grant from Marion Laboratories, Inc. From 1:30 - 5:00 PM, the videotapes can be seen in the Redwood Room.

LOCATION

2:30 PM	IDEA EXCHANGE SESSION/COFFEE BREAK	
2:45 PM	PLENARY SESSION PANEL DISCUSSION **"The Role of GECs in Community Development"** Linda Brasfield, M.S.*, *OVAR GEC* David Haber, Ph.D., *Creighton Regional GEC* Eric Rankin, Ph.D., *Great Lakes GEC* Carlos Oppenheimer, M.D., *GEC of Puerto Rico*	Juniper
3:45 PM	EVALUATION OF SESSION Carl Fasser, P.A.-C., *TCGEC*	Juniper
4:00 PM	INDIVIDUAL STUDY	
	HOUSTON IN THE EVENING (Dinner and entertainment on your own)	

Sunday, April 24, 1988

9:00 AM	MEETING WITH FEDERAL PROJECT OFFICERS (Coffee/Juice Provided) Dr. Carol Gleich, Mr. William Koenig, and Dr. Tom Louden	Cedar, Laurel Pine
9:45 AM	BRUNCH AND CLOSING PLENARY PANEL SESSION **"Future Directions for Geriatric Education Centers"** Evan Calkins, M.D.*, *Western New York GEC* John Beck, M.D., *California GEC* Jerome Kowal, M.D., *Case Western Reserve GEC* Terry Fulmer, R.N., Ph.D., *Columbia University*	Juniper
11:15 AM	EVALUATION OF SESSION AND WORKSHOP Carl Fasser, P.A.-C., *TCGEC*	Juniper
11:30 AM	WRAP-UP OF WORKSHOP AND ADJOURNMENT Drs. Roush and Gleich	Juniper

* Facilitator

FOURTH WORKSHOP FOR KEY STAFF OF GECs

Title: WELCOME, INTRODUCTION AND REVIEW OF PURPOSES

Welcome and Statement of Purposes

Objective(s):

- o Review those instructional methods used to prepare and strengthen key faculty in geriatrics and gerontology.
- o Describe characteristics of project staff and trainees involved in the national GEC network and document the nature of their educational experiences in gerontology and geriatrics.
- o Facilitate establishment of affiliations between new and current GECs.
- o Identify current offerings in geriatrics within the curricula for each discipline in each GEC.
- o Share developed curricula relating to diagnosis, treatment, and prevention of diseases and other health concerns of the elderly.
- o Determine potential opportunities for the advancement of geriatric education within each GEC's area or region.
- o Promote organizational arrangements and administrative entities which improve education in geriatrics.

Presenter(s): Thomas Louden, D.D.S., Director, Division of Associated and Dental Health Professions

Carol Gleich, Ph.D., Project Officer, Fourth Workshop for Key Staff of GECs

Dr. Louden welcomed attendants from the then 31 GECs to the Fourth Workshop of Geriatric Education Centers and thanked Dr. Roush, Mr. Fasser, and Ms. Wright and associates at Baylor College of Medicine for having put together the program. Dr. Louden also recognized Lorraine Thompson from the Administration on Aging.

Dr. Sundwald, HRSA Director, wanted an interagency agreement with the Commissioner of the Administration on Aging. Two areas of conjoint activity between the Health Resources and Services Administration and the Administration on Aging were promotion of staff development strategies to enhance the community migrant health centers and Indian health services programs.

Another area of mutual interest was dissemination to universities and other training institutions of materials developed under AoA and HRSA educational training programs. Also, GEC-developed training and curriculum materials will be distributed to the AoA for their distribution to their agencies.
Still another plan was to maximize the coordination between AoA gerontology education training programs, especially their new national resource center, and the Health Resources and Services Administration geriatric training programs, such as the GECs. Special emphasis would be on the development and dissemination of curricular materials in training health professionals about the special needs of minority older patients.

Dr. Louden mentioned the conference planned on rehabilitation in geriatric education for December 4 and 5, 1988 to be held in Washington, D.C. at which table clinics are planned to display what the GECs have been and are doing in their communities.

A final point brought to participants' attention was the plan to collaborate on the development of a national strategy for the training of in-home aides. Training in-home aides has not been a responsibility of the Bureau of Health

Professions since they are not classified as one of the professional groups identified by Title VII Health Service Act. But in-home aides are an important group of people that need to be better educated to care for elderly persons as much as possible in their own home and surroundings. These are the kinds of things that are being considered for interagency agreements between HRSA and the Administration on Aging.

Dr. Gleich added her welcome to that of Dr. Louden and thanked the Baylor staff for having put the program together. She also acknowledged the important role the planning committee played in developing the program.

Dr. Gleich added that the contract called for the then nine new GECs having a one-day orientation prior to convening the workshop: these were University of Florida GEC, University of South Florida, Great Lakes GEC, GEC of Michigan, New Mexico GEC, Creighton Regional GEC, Stanford GEC, Pacific Islands GEC-Hawaii, and the California GEC.

The basic purpose of the workshop was to interact and share information and work together so that GECs can move forward as a group. The four task forces developed last year evolved into work groups, but the four basic missions developed last year are still incorporated: community linkages, project assessment, policy and planning, and geriatric education.

Title: **PLENARY SESSION ADDRESS: "RELATIONSHIP OF GERIATRIC EDUCATION TO SERVICE DELIVERY MODELS"**

Relationship of Geriatric Education to Service Delivery Models

Objective(s):

- Describe factors contributing to the need for alternative out-patient settings for health care delivery.
- Discuss trends in health promotion, health protection, and illness prevention for older individuals.
- Consider the implications of these shifts within the health care industry relative to educational experiences in geriatrics.

Presenter: Itamar Abrass, M.D., Director, Northwest GEC, Keynote Speaker.

Dr. Itamar Abrass' edited remarks constitute the following summary of this session.

The general topic was one of the major issues that needs to be addressed in geriatric medicine now as opposed to saying everyone needs to know geriatrics and take better care of our elderly. The issue to be dealt with is a change in atmosphere and the sites where care for the elderly is rendered and how we should train individuals to care for the elderly in settings other than in the traditional acute hospital.

Life spans are getting relatively close to the generally accepted survival curve and people are probably not going to live a lot longer. Since 1960, for those individuals over 65 and those over 75, the trend has been an upward one. Compared to individuals who lived to age 75 in 1900 relative to those 75 years old in 1960, the latter didn't live any longer than somebody who got there in 1900. The real change, particularly in the last 10 years, but certainly over the last 20 years or so, is that individuals over the age of 65, and particularly those over the age of 75, are living longer by 2.5 years.

The next issue came from Fries' 1980 paper in the New England Journal of Medicine in which the author stated that while people are living longer, the other thing that will happen over time is a decrease in the time period people develop chronic disease resulting in disabling conditions. Fries called this the compression of morbidity. The question is, "Is Fries' idea really true?"

Data from Northern Ireland recently published in the Lancet reported the age of individuals when they enter a long-term care facility for a prolonged period of time, not people who spend a week or two after a major operative procedure and then get discharged. What's happening, particularly for women, but the trend is the same for men, is that people really are older at the age that they enter a long-term care facility for true long-term care. Thus, people are entering nursing homes or long-term care facilities at later ages and they're staying longer.

What can be observed in the community? About 19% of the individuals over the age of 65 have some functional disability that requires assistance, either in their IADLs or in their ADLs. As they get older, people need more and more assistance; almost half the people over the age of 85 need some assistance in care.

What are the major causes of mortality? Heart disease, (there are health promotion disease prevention strategies that have impacted the decline in heart disease), cancer (the issue of smoking), hypertension, chronic obstructive pulmonary disease, pneumonia, influenza (the issue of vaccination), and sequela of falls, which is the major cause of injuries in the elderly. If one looks at the causes related to mortality in the elderly, all have aspects for opportunities to decrease mortality.

What are the disorders contributing to activity limitations? Heart disease and arthritis are the two major ones, with visual impairments and high blood pressure being diseases about which we can make major health promotion and disease prevention interventions that can make a difference in the disorders that decrease limitation of activity.

The Surgeon General's publication, Healthy People, recommended (1) maintenance of social activities, including work, as opposed to the general trend of retirement, (2) engaging in regular exercise, (3) specific nutritional needs, and (4) getting periodic health check-ups.

Other recommendations included simplification of medications, consulting physicians about immunizations, enhancing home safety particularly related to falls, and having available home services so the elderly can stay at home. The traditional site for training has clearly been the acute hospital. But what's happening to our acute hospital? For a host of reasons, length of stay is shortening, not just due to DRGs, but changing technology contributes to length of stay. Most of the people are at the end stage of their chronic diseases when they're in the hospital. They're no longer in that setting where one can make some major impact as a result of health promotion disease prevention. A trainee taking care of a patient in an ICU who is in gram negative sepsis doesn't want to hear from the geriatrician about whether or not the person got his or her pneumococcal vaccination or was immunized for influenza this week.

In looking at the high priority services previously mentioned, we must begin to deal with geriatric education in different settings; the acute hospital is not the place in which that can be done effectively. Thus, these questions must be answered: What sort of sites are needed to be developed and what kind of curriculum do we use to do this? How can teams be trained to care for individuals in nursing homes? Where and how does one teach various providers health promotion and disease prevention issues? And when and where in the curriculum are rehabilitation issues dealt with?

Dr. Abrass closed his presentation by suggesting that throughout the remainder of the conference, the conferees discuss ways of developing the kind of training and the kind of personnel who are going to meet these high priority services.

TITLE: PANEL DISCUSSION: RELATIONSHIP OF GERIATRIC EDUCATION TO SERVICE DELIVERY MODELS

Objective(s):

- Debate the implications of alternative care settings for geriatric education programs.
- Challenge the benefits to be derived by changes in at-risk behavior exhibited by older individuals.
- Question whether there should be a direct relationship between geriatrics education and service delivery models.

Presenter(s): Glen Hughes, M.D., Univ. of Alabama GEC
Margaret Dimond, R.N., Ph.D., Intermountain West GEC
Robert J. Luchi, M.D., Director, Huffington Center on Aging, Baylor College of Medicine

Dr. Luchi said one approach to some of the specific issues that Dr. Abrass raised is an emphasis on home and community care. Based on local experience gained in Houston, some fundamental principles regarding delivery of health care have been rediscovered as a result of operating a new day center for patients with Alzheimer's disease and related disorders. The center was developed by the local Sheltering Arms Group, a hospice program and a long-term, noninstitutional care program. It also served as a preclinical elective experience for medical students and was entitled "Aging, Health and Community Care".

Of the four things relearned in going through these experiences, the first is that it is essential to make sure that the clinical activities have matured to the point where everything is working smoothly before adding the additional stress of an educational program. Also it helps to have a research component in place prior to an educational effort because the spirit of inquiry and analysis add to the richness of an environment in which clinical education takes place.

The second principle relearned is that students are time consumers, not time savers. Don't take students and expect that they're going to help you get through your day in a shorter amount of time than you're already spending. They're going to extend your day. It's critical to establish at the beginning the commitment to teaching and to reestablish periodically that commitment because things change in major ways, e.g., maternity leave, illness, cut backs in funding, loss of staff, etc.

The third lesson relearned is that appropriate field experiences should be devised. It is always possible to fall into the "field-trip experience trap." How can you avoid this and deepen the experience? For example, when our students visit the elder law clinic, we insist that they interview the recipients of the care so that they can get a well-rounded picture of what's going on. They bring back a report critiqued by our faculty and by the lawyers and the law firm so that feedback to the students closes the loop in a way we think avoids the trap of just another field trip experience.

And the last thing relearned is, in training students for the real world, make sure they can generalize the experience. The more universal the experience the better, e.g., a hospice program can be used for students and fellows to learn about death and dying. Inasmuch as the mortality rate is 100%, and since these issues are ever present, they will be able to use the principles and practice that they've been taught in other settings.

Dr. Dimond stated that a major issue facing gerontological nursing, and probably other disciplines as well, is practice and development. In a 1986 survey conducted by the American Nurses Association, forty percent of the faculty responsible for teaching gerontological content were reported to have had no formal educational preparation for their teaching. Similarly, clinical preceptors or supervisors of students were not formally prepared in geriatric nursing. An overwhelming majority of schools indicated that students continued to receive clinical experience with older adults in acute facilities. The emphasis in nursing curricula, when it does focus on elders, is a continued emphasis on acute illness rather than on health promotion and health maintenance. A majority of the survey respondents indicated preference for an integrated curriculum in which gerontological/geriatric content is included rather than separate courses in geriatric nursing. The central issue is faculty development, without which discussing curriculum development or alternative clinical sites or interdisciplinary experiences for students is meaningless. Regarding alternative care settings, one of the best ways students get some kind of an introduction to the older individual is for them to work with well elderly, not with people in institutions, not even with people who are coming to traditional clinical settings. Ambulatory or home health care provides opportunities for students to learn common illnesses of the elderly; what they see in university hospitals are usually catastrophes. Students in home care and ambulatory settings have opportunities to learn how to deliver sensitive care to the elderly and get first-hand information on all of the available services needed for older people and how those all need to be coordinated. Furthermore, home care opportunities offer the student the chance to look at the functional ability or disability level of the individual right in the place where they are living, and in many cases, deal with the issues surrounding dying and grief.

Since all older people have chronic conditions, we need a whole new definition of wellness for individuals with chronic conditions. Health needs to be stressed at least as much as illness in the curriculum. For nurses a heavy emphasis should be placed on the frail elderly who frequently are not in need of medical care, but are very much in need of nursing care. Other major areas of curriculum and faculty development and student learning exercises in geriatrics should deal with bioethics and how scarce resources are allocated, i.e., high-tech options and quality of life for elders. Good ways to relate geriatric education with service models, e.g., the teaching nursing home concept, must be found.

Dr. Hughes said that primary prevention is a concept that allows us to think in terms of not only improving quality of life, but helping the health of our country's economy by reducing disability days, etc. However, it is a concept that can have some danger associated with it if one becomes overzealous in an effort to make decisions for individual patients. Most of the studies on primary prevention have been based upon middle age and younger subjects. There is a dearth of data that look at risks among older individuals and the impact of intervening for that risk itself. Hypertension is a classic risk factor on which intervention actively reduces cardiovascular disease mortality. Although Framingham has generated much valuable information regarding cholesterol, what one sees is a strong correlation between cholesterol and cardiovascular disease that diminishes over time until the relationship becomes tenuous regarding the elderly. When looking at risk-factor programs, what one sees is that risk-factor decisions are made upon algorithms based upon younger individuals, and developing algorithms for older persons is a very difficult task because there simply isn't that much available data.

The point is that decisions need to be based upon valid, reliable data, for the odds ratio for dealing with older individuals is quite different than it is when dealing with younger individuals. Quality of life must be considered as a much more profound variable when looking at older people in terms of cost-benefit analysis than with younger populations.

Community screening programs do not usually demonstrate benefits commensurate with efforts; however, if reimbursement is allowed for primary prevention activities, then there would be more demonstration projects funded across the country.

Through the GECs, the opportunity, perhaps even obligation, exists to make prevention a cornerstone of our training efforts, but in doing these things make sure decisions are data-based ones and exercise extreme caution due to the nature of the population being dealt with.

Title: TASK FORCE REPORTS TO PLENARY SESSION

Linkage Building; Evaluation; Curriculum; Issues and Trends

Objective(s):

- Provide overview of earlier task force activities.
- Describe activities accomplished since previous meeting.
- Identify areas specified as being in need of continued attention.

Presenter(s): Michele Saunders, D.M.D., M.S., M.P.H., South Texas GEC
Jurgis Karuza, Ph.D., Western New York GEC
Davis Gardner, M.A., OVAR GEC
Bernice Parlak, M.S.W., GEC of Pennsylvania

Linkage Building

During this past year the linkage task force has focused on Virginia Commonwealth University's audiovisual teleconference, on the South Texas GEC's audio teleconferencing, and Alabama's electronic bulletin board.

Dr. Saunders inquired about the number of GECs participating in VCU's teleconference: three GECs had participated.

As far as the electronic bulletin board at Alabama, there are 18 institutions utilizing this service: three of those are GECs, however, several GECs did not have modems last year whereas eight more have attained modems and just have not had the time to install them. Thus, 11 of 31 GECs with modem capability are progressing in the right direction. We need more direction about what kind of use we can make of electronic bulletin board other than for a calendar. One request frequently heard, particularly from the new GECs, was that they would like more access to resources through the bulletin board.

Regarding abstracts, the Bureau did not send copies of GEC abstracts, but there is an updated listing of GEC abstracts and Dr. Gleich did have those prepared and they will be available at the table clinic.

Dr. Saunders pointed to the hard work of the SUNY Buffalo staff in developing a new directory which was made available at the meeting.

A suggestion was made regarding the problem with PBX-switchboard people at the universities not knowing about the existence of GECs.
A request has been made that we consider thinking about a short monthly newsletter to all GECs about linkage opportunities, idea sharing, etc.

Evaluation

Dr. Karuza recounted that the task force met for the first time last year in Buffalo, and he introduced Dr. Richard Hubbard from the Case Western GEC to present a synopsis of what has happened.

Dr. Hubbard described the reporting mechanism that has been proposed that was designed to be generic in nature and document basic commonalities that the centers share.

Project directors were using the form as part of their progress summary reports to begin establishing the categories and numbers of people with whom they're working.

Everyone was encouraged to use it in some sort of modified form so that it might be possible to collapse across the GEC movement in order to orchestrate a real national representation of the variety of people and disciplines that GECs trained.

Dr. Hubbard mentioned that a special issue of Gerontology and Geriatric Education would be published soon that represents the contribution of evaluation of programs from about 14 different GECs. (See Vol. 8, Nos.3/4, 1988.)

Curriculum

Ms. Davis Gardner referred the audience to a written report in their packets made on behalf of the co-facilitators of the curriculum task force that was appointed and began work last year in Buffalo.

The curriculum task force had focused on producing a curriculum product to save faculty and preceptors the planning and organization time in developing an interdisciplinary approach. Dr. Lucille Nahemow's geriatric diagnostic case study approach from the University of Connecticut GEC was chosen as a model from which guidelines could be developed.
In conjunction with Dr. Lisa Leonard with the Texas Consortium, those guidelines were developed and were sent out for review. Preliminary reports indicated that the format for the instructional process was very workable and, as an instructional strategy and outline for faculty discussion, saved them developmental time, if followed.

A subgroup of the task force developed a draft of an evaluation form that certainly will be needed as these case studies are tested so that the final product stands up to rigorous inspection. Another subgroup was developing the outline of a monograph on the subject.

The work group to continue this effort will be guided by Dr. Lucille Nahemow.

Issues and Trends

Gloria Barry, R.N., Ph.D., Director of Educational Programs at the Geriatric Education Center of Pennsylvania, presented greetings from Bernice Parlak who was not able to attend due to illness and read her report on the Issues and Trends Task Force.

The Issues and Trends Task Force was established at the Third Geriatric Education Workshop in Buffalo, New York, 1987, and was to serve as the nexus of a multitude of conceived and yet to be conceived topics affecting the daily operations, future stability, and nationwide impact of the geriatric education center initiative.

Since the task force dealt with such a wide range of topics, members were organized into three major groups for discussion purposes: (1) the administrative issues group--the group discussion focused on (a) ongoing support of geriatric centers; (b) opportunities for foundation and corporate funding; (c) effectiveness of consortial arrangement; and (d) development and managerial barriers to implementing interdisciplinary geriatric education; (2) a discussion group on melding gerontology and geriatrics explored ways in which the health science and social science disciplines can work together productively; and (3) a third discussion group centered on geriatric education and the market place which focused on the responsibilities of the GECs beyond the immediate faculty development program and included discussions on the responsibilities of the GECs to (a) health service systems and the aging network as as these groups serve a more frail group of older persons, (b) hospitals,

(c) home health agencies, (d) community health centers, (e) Veterans Administration programs, and (f) finally to consumer groups.

The task force agreed to attempt the following: (1) explore both formal and informal linkages between the GECs and other national organizations and associations in an attempt to promote both geriatric education as well as to promote the geriatric education centers; (2) a subcommittee would explore the need to survey the GEC's directors on the topic of administrative structure and funding sources currently in place; and (3) a small subcommittee of three persons would develop a study protocol to determine the impact of current educational trends of college-age and older age groups particularly women returning to the work force and minority groups on the subject of geriatric education.

Results of these efforts are (1) establishing GEC/Association linkages was not deemed likely since established organizations generally "affiliate" with formally organized and already empowered groups; however, through papers, presentations, or service on committees the impact of the GECs was being made. (One example of the type of linking, dialoguing effort is an article entitled "The Challenge of Caregiver Education, Gerontology and Geriatrics" in the January-February 1988 issue of the Association of Gerontology and Higher Education's Newsletter, authored by Dr. Richard Hubbard, Western Reserve GEC, representing geriatric education and Dr. Harvey Stearn from the University of Akron representing the gerontological prospective.); (2) the plan of the task force to conduct a survey on administrative structures and funding resources did not prove to be realistic at that time; and (3) the small subcommittee focusing on the demographic impact trends study has been hindered by illness and reassignment of members.

As the transition from task forces to the work group format occurs, many of the issues chosen for discussion and promotion need more definitive consensus before actual work can process. The initiation of the policy and planning work group is a natural, well-founded developmental step.

Title: TRANSITION OF TASK FORCES TO WORK GROUPS

Group A: Linkage and Communication Work Group

Objective:

- Convene gathering of center representatives interested in pursuing means by which to facilitate inter-center linkages and communicate information regarding activities and resources.

Presenter(s): Gloria Barry, R.N., Ph.D., GEC of Pennsylvania, facilitator
George Magner, Ph.D., TCGEC, recorder

Substantial linkages have resulted from efforts of past task force work.

General recommendations were (1) not to have a formal task force or work group, rather, a special interest group, loosely formed, with informal meetings scheduled at annual meetings and (2) not to develop an instrument to collect information on community and institutional linkages at this time.

Other specific recommendations were to (a) update directory, (b) continue annual meetings of GECs, (c) continue mid-year GSA meeting, (d) circulate newsletters, (e) encourage Alabama GEC to reopen access to electronic bulletin board, (f) provide periodic update to new GECs, (g) develop a summary resource sheet to mail or make available at annual meetings, (h) encourage GEC linkages on a regional basis, (i) utilize joint GEC meetings on topics of broad, central interests (e.g. ethnicity), and (j) encourage educational activities in collaboration with non GEC-based disciplines or special interest groups within a state or region.

It was suggested that the Bureau support and underwrite an exhibit booth at national meetings such as GSA for the purpose of advertising the national GEC network. Each GEC who would like to distribute brochures could contribute a nominal fee which would go against the total exhibit fee.

The GEC of Pennsylvania will continue to serve as the focal point for any subsequent involvement or activity in this broad area of inter/intra GEC linkages.

Group B: Project Assessment Work Group

Objective:

- Convene gathering of center representatives interested in collaboration on efforts designed to better characterize the outcomes of geriatric education center activities.

Presenter(s): Deborah E. Simpson, Ph.D., Midwest GEC, facilitator
Ted Sparling, Dr.P.H., TCGEC, recorder

A need for a centralized approach/clearinghouse model to share information about evaluation models and to keep copies of evaluation instruments was presented.

The difficulty in conducting impact evaluations came in the identification of measurable variables which are relevant to the goals of the GEC's. For example, one major goal is to improve the quality of care provided to the elderly. The number and complexity of the intervening variables between the GEC's primary audience (faculty, trainees, workshop attendees), and this impact goal made this type of evaluation study tenuous. One major area that could serve as a focus for combined evaluation efforts is the multidisciplinary aspect of the GEC programs.

Evaluation to improve the quality of the educational/teaching programs provided as part of the GECs is viable and practical. Again the clearinghouse function described above could serve to facilitate this process.

Prior to the next GEC workshop, a data-gathering effort will be implemented to ascertain from all GECs (a) what evaluation questions they are addressing, (b) how they will determine if the answers to those questions are positive, and (c) what evaluation topics would they like to pursue as a "special interest group". The results would be collated and disseminated to all respondents. If there is overlap in the special interest topics, a "volunteer" would coordinate the activities of those individuals and forward results to a central location. Bi-annually, the progress of these interest groups would be reported to all GECs, along with an updated evaluation reading/reference list. This activity will be coordinated by the Midwest GEC.

Molly Engle, Ph.D., from UAB agreed to serve as coordinator of the work group.

Group C: Geriatric Education Work Group

Objective:

- Convene gathering of center representatives interested in pursuing projects directed at facilitating the educational mission of geriatric education centers.

Presenter(s): Lucille Nahemow, Ph.D., University of Connecticut, GEC, facilitator

Marie Koch, M.S., P.T., TCGEC, recorder

Discussion ensued regarding participants on this task force; active members were from Buffalo, Seattle, Utah, Missouri, Texas, Mississippi, and Iowa.

Discussion continued on the charge given this task force at the last workshop that the curriculum group was to meet and a product was expected.

Lucille Nahemow, Ph.D., Connecticut GEC, was named as the liaison from this group. Dr. Nahemow, along with the HRSA, will serve as the spokepersons for this work group regarding information about its activities.

The case studies of various projects will culminate in the monograph, which was the project decided upon last year.

The interested members agreed to meet again at the GSA meeting, November 18-22, 1988, in San Francisco.

Group D: Policy and Planning Work Group

Objective:

- Convene gathering of center representatives interested in considering actions taken that promote geriatrics and the education of health professionals engaged in the field.

Presenter(s): Gerald Goodenough, M.D., Intermountain West GEC, facilitator
Otto Van Duyn, Ph.D., TCGEC, recorder

Dr. Goodenough convened the gathering of approximately 25 GEC representatives interested in considering actions that promote geriatrics and the education of health professions. The group decided to keep the Policy and Planning Work Group as the name for this group. **Bernice Parlak**, M.S.W., GEC of Pennsylvania and **Patricia Blanchette**, M.D., M.P.H., Pacific Islands GEC, were chosen to serve as co-coordinators for this work group. The following issues were discussed as topics that will be explored and expanded within the scope of work and/or interest of this group:

- national policy for geriatric and gerontological education,
- the incorporation of education in different settings,
- teaching and care of elderly services,
- how current research is phased into the educational offerings,
- address as a GEC the issue of scarce allocation of resources,
- recruitment of minority faculty and care of minority people,
- influence of career choices in elderly care,
- special interest age groups such as the retarded and disabled who become elderly,

- the interrelationship of internal and family medicine and various other disciplines, and
- GECs' relationship to professional organizations and societies.

There will be contact among the group at the GSA or AGS meeting. Recommendations and reports will be available on the activities of the work group at the Fifth GEC Workshop.

TITLE: PLENARY SESSION ADDRESS: ISSUES IN GERIATRIC EDUCATION

OBJECTIVE(s):

- Identify the various demographic, economic, and policy issues impacting on our society's response to the needs of older Americans.
- Along with other federal perspectives and initiatives, discuss the mission of the GEC grant program in the context of these issues.

PRESENTER: Tom Hatch, Associate Administrator, Health Resources and Services Administration U.S. Public Health Service.

In presenting Dr. David Sundwald's prepared remarks, **Mr. Hatch** stated that HRSA's perspective on geriatrics is shaped by the agency's involvement in a number of federal programs. Recently he represented HRSA as Co-Chair with T. Franklin Williams of the NIA in preparing the document, Report to Congress on Personnel for the Health Needs of the Elderly Through the Year 2020.

Findings from this report were (1) the 65 and older population is growing faster than any other group in the nation, (2) the 85 and older age group is the fastest growing segment of the elderly, and (3) the "youngest" old, those 65 through 74, will take the honors between 2000 and 2020. These demographics signal an expansion in the demand for health services, particularly prevention and health promotion, primary care, long-term, hospice, and rehabilitative care. The care of older Americans may comprise one-third to two-thirds of the future workloads of most physicians and other health personnel. In light of this forecast, we recommended to Congress that geriatric education and training programs need to be expanded. We specifically cited the Geriatric Education Centers as a good example of accomplishing this.

Congress also directed us to study possible changes in Medicare and third-party reimbursement programs that support geriatric education. The financing of services is closely entwined with the financing of educational programs. It is also a factor in shaping faculty and student interest and attitudes toward the field of aging.

In April 1986, Congress acted to encourage residency and fellowship training in geriatric medicine at the same time they imposed limits on other Medicare direct cost reimbursements. HRSA has been assigned the responsibility to study this so-called "geriatric exception" and make recommendations by July 1990.

It appeared that Congress took our findings on the increasing number of elderly to heart because they also authorized a fellowship program to train or retrain medical and dental school faculty in geriatrics. This new activity authorized under section 788(E) of the Public Health Services Act is for only one year because all health professions and nurse education legislative authorities expire at the end of the current fiscal year.

HRSA co-sponsored the Surgeon General's Workshop on Health Promotion which resulted in these recommendations: First, there was a consensus that attitudinal/consciousness raising is still necessary among the general public and among health providers. Second, participants seemed to agree that the ability to assess functional status is critical to the provision of quality care. Third, there was a general consensus that a multidisciplinary approach to training and care is the best approach in the field of aging. And fourth, it seemed that most of those present felt that the responsibility for geriatric education should be jointly shared by the federal government, states and the private sector.

The administration will be proposing a major reform of Titles VII and VIII. The new proposal for "cooperative health professions initiatives" would replace the categorical authorities. The budget proposal for those Titles specifically mentions "strengthening geriatric training" as some of the areas of special attention. It emphasizes cooperative or consortia-type arrangements of health professions schools and programs as well as the marshalling of non-federal sources of funding.

A new bill (S22290) formally introduced by Senator Kennedy includes a special new section that stands alone in dealing with geriatrics. One section would include geriatric centers and training and would be essentially the same authority under which the current geriatric center is authorized. Another section includes the geriatric fellowship program for training medical and dental faculty. Significantly, the authorization level for the geriatric training part of the authority is $20 million. In general, the federal atmosphere appears to be not just receptive, but proactive in terms of considering and planning for the anticipated future expansion of the number of elder Americans. I think that the Geriatric Education Centers represent HRSA's proudest effort toward that end.

Title: PANEL DISCUSSION: ISSUES IN GERIATRIC EDUCATION

Objective(s):

- Pursue impact of competing budgetary areas on funding for aging-related research and education.
- Discuss health policy issues as they relate to competition for limited resources, i.e., aging/long-term care versus homeless versus drug abuse.
- Consider the importance of education in geriatric medicine as a health policy agenda.

Presenter(s): Richard Besdine, M.D., Director, University of Connecticut GEC
Rose Dobrof, D.S.W., Co-director Hunter/Mt. Sinai GEC
Eric Pfeiffer, M.D., Director, University of South Florida GEC

Dr. Besdine apprised the audience that upon moving from Harvard he assumed responsibility for the Traveler's Center on Aging at Connecticut in addition to the Professorship in Geriatrics and Gerontology. He then introduced his co-panelists: Dr. Rose DoBrof, Brookdale Professor of Gerontology at the Hunter College School of Social Work and Director of the Brookdale Center on Aging at Hunter College and Co-Director of the Hunter/Mt. Sinai Geriatric Education Center; Eric Pfeiffer, M.D., Distinguished Professor of Psychiatry, Director of the Sun Coast Gerontology Center and Director of the Geriatric Education Center, all at the University of South Florida.

Dr. Dobrof stated that geriatric and gerontological education, as an item on our health policy agendas in both the public-governmental sector and the voluntary-private sector, for the professionals who are to deliver health and social services to older Americans should be a high priority on governmental and foundation agendas.

In general, universities have not done a good job of convincing members of Congress that there really is a connection between research and education and services for older people.

The New York Times of April 17 was cited; the headline was "Health Worker Shortage is Worsening," and the second paragraph began with "the problem is expected to escalate, medical experts say, with the advent of new technology and an increase in the number of older Americans, the heaviest users of health care."

Based on the foregoing, two points were made. We must now recognize that the GECs, individually and collectively, represent a critical mass of leadership. And, we must face the reality that education and research don't pluck at the heart strings of either legislators or foundation and corporate grant makers; few of us are in the position to mobilize hundreds of older people to speak on our behalf. If research and education are to be a central part of the health policy of our nation and if professionals already in the field are to receive the kind of education they need and if new recruits are to be attracted to gerontology and geriatrics, then it must now be required of us that we take the leadership in this struggle.

The work groups must include in their agenda ways of linking the GECs so that we can engage together in public education activities designed to affect the health policy agenda so that it includes a high priority to education and research.

The GEC faculty and staffs must engage themselves with the foundations. We have the sterling examples of Dana, Travelers, Brookdale, Robert Wood Johnson, Hartford, and other foundations who have placed a priority on geriatric fellowship awards and fellowship programs. But we can list those foundations on two hands at most.

If we recognize the leadership potential that we represent and exert that leadership, we run the risk of appearing at times to be self-serving, but the goal of preparing professionals who can provide quality care to older people is worth that risk.

Dr.Pfeiffer reported that a number of federal efforts have stimulated the inclusion of geriatric education in our health sciences campuses, but academic health sciences campuses did not maintain most programs when federal funds ran out.

An example of an incomplete federal initiative is when the Veterans Administration recognized that the aging veteran would require special care and responded by developing the GRECC program, oftentimes in affiliation with an academic health sciences campus. While these have been significant contributions, they, nevertheless, have not in any way covered the entire United

States. They've been localized to several critical sites within the VA system, and while they still persist, cannot be said to have really mainstreamed geriatric medicine in our academic health sciences campuses.

Another major effort began under the leadership of the first director of the National Institute on Aging with the Geriatric Academic Medicine Award. A number of young and some older faculty members were trained especially in the arena of geriatrics and gerontology and the teaching of the same. Again, upon expiration of some of these grant mechanisms, the initiatives that were developed but which did not establish in-house and ongoing continuation mechanisms through mainstreaming were discontinued.

A third major initiative came from the Administration on Aging, which developed a long-term care gerontology center program that ran for about five years. Eleven centers were involved, one in each of the HHS regions, with two being in one of the regions. When funding terminated, as it did several years ago, only a few survived. A major discriminating factor between those that survived and those that disappeared was the amount of funding that the parent university had put into these centers in the first place. Those that had little funding from the parent university had little chance of surviving beyond the federal funding. Now, the GEC program is the largest, most widespread in terms of numbers and geographic distribution of any of the federal initiatives in geriatrics. Thus, a significant concern should be that we will again experience the dissolution of some of these centers, while in others they will stimulate the inclusion of geriatrics education as a mainstream activity.

The question to ask this group, which represents the total leadership in geriatric education centers, is, "How do we get from this point to the next point which is the inclusion of geriatric education as an ongoing non-externally implanted, mainstreamed activity in proportion to the amount of health care that is delivered to the elderly?"

Perhaps the beginning of an answer lies in the examples of advocacy for certain kinds of activities from lay groups in lieu of professionals advocating for themselves, e.g., the American Cancer Society, the American Heart Association, and, most recently and perhaps most dramatically, the Alzheimer's Disease and Related Disorders Association. The total field of geriatrics is not so neatly packaged as the disease-specific groups; it is much broader, much wider, it is sometimes more prosaic, sometimes less dramatic and yet, when one looks at the total magnitude of the problem, it is profound. There needs to be, in addition to the efforts by professionals in the field and the federal government, some development by advocacy groups that are lay representatives, that are advocates for this same issue on behalf of letter writers, voters, consumers. There is as yet not a sufficiently educated public consumer group that can advocate for health care services for the elderly because they don't know exactly what they should be asking for. Lay groups such as AARP that have the capability organizationally and in terms of volume of their numbers need to do that.

Another question to be posed is, "Has geriatrics found a home in our health sciences campuses and, if so, where is it?" The GRECCs emphasized a center concept. Long-term care gerontology centers emphasized a center concept. Now GECs are emphasizing a center concept. Centers, in terms of the power of an organization like a medical school where departments function almost autonomously, usually don't enjoy comparable power bases.

The nature of geriatrics had led us to create centers; however, administratively, centers have not had the power to move institutions because they have been somewhat externally imposed. Since the GEC program is the most widespread of the various federal initiatives to date, mainstreaming these efforts should be a high priority.

Dr. Besdine's concluding remarks began with this observation: one needs multiple professionals cooperating in the evaluation, management and continuing assessment of health intervention for older people, i.e., an interdisciplinary team.

In addition to interdisciplinary collaborations being required for successful, adequate health care of older people, it's also required for education, and it's also required in research related to care.

The Dana Foundation will soon be distributing guidelines for preliminary proposals that will create interdisciplinary education of physicians in geriatrics and geriatric research in preparation for larger awards related to the conduct of interdisciplinary geriatric research as well as in current training of fellows to do that research.

Medicine alone can be very strong vertically, but without interdisciplinary care, education, and research so essential for adequate outcomes medicine alone is not enough in any of those areas of activity.

Through fellowships and faculty retraining, we can create adequate competencies in American medicine for geriatric care.

A strong program in medicine can offer an entry point to the daily mechanisms of health care in an appropriate environment, and, if there is good geriatric medicine, that can be the platform on which one can aggregate learners and faculty in all other disciplines related to health care. We need to utilize as clinical sites inpatient geriatric assessment units, Alzheimer's units, teaching nursing homes, ambulatory geriatric clinics, day programs, and day hospitals in order for geriatric medicine to exert a leadership role in affording opportunities to bring faculty from other disciplines together to teach students interdisciplinarily.

Title: GEC STAFF DEVELOPMENT SESSIONS AND GROUP REPORTS TO PLENARY SESSIONS

Group A: Strategies for Curriculum Integration

Objective(s):

- **Explore factors identified as impeding the integration of geriatric content within educational programs for health-related disciplines.**
- **Discuss the implication of these factors for the future of geriatric education within academic settings.**
- **Consider strategies for the integration of curriculum content within academic institutions that address identified impediments.**

Presenter(s): **George J. Caranasos, M.D., Director, Univ. of Florida GEC, facilitator**
Mark Stratton, Pharm.D., Director, New Mexico GEC
Rosemary Orgren, Ph.D., California GEC

Drs. Caranos, Stratton, and Orgren each contributed to the following summary of this session.

Dr. Caranasos introduced his co-panelists. The session was begun by Dr. Caranasos posing three questions: What are the barriers to inclusion of geriatrics in health professions curricula? What are the implications of not having adequate geriatric content in the curriculum? What are effective strategies to overcome those barriers?

Barriers included (1) limited interest on the part of faculty and students; (2) limited curriculum time; (3) organizational inattention; (4) geriatrics is perceived as "soft" or unimportant; (5) lack of adequately prepared faculty and faculty development; (6) resistance to changes; and (7) lack of a formalized interdisciplinary structure through which geriatrics can be appropriately placed in the curriculum. Two other observations were made by Dr. Caranasos: the lack of geriatrics being taught tends to confirm in the minds of many that it is unimportant or it would receive greater attention and time; and the [simple, but elegant] thought that since geriatrics is everyone's business, it does not devolve on any single group, thus suffers from lack of locus.

Implications of these barriers were (1) prevention of the integration of geriatrics at a student-entry level; (2) reinforces unimportance of geriatrics and geriatric patients; and (3) loss of prestige and support for faculty interest. The net result was lack of geriatric knowledge among health care professionals and, perhaps, a concomitant level of inadequate care for the elderly.

Strategies and solutions recommended were (1) influence administrators and those who want to become administrators; (2) devise faculty education to increase interest through involvement and soft-sell approaches, e.g., invite uninvolved faculty to present a lecture on geriatrics in their field; (3) increase elective offerings; (4) offer required courses early in curriculum; (5) co-opt pressures from community organizations, professional organizations; (6) require for accreditation of various programs that specific persons have bonafide training in geriatrics; and (7) employ traditional marketing techniques.

Group B: Interdisciplinary Education in Geriatrics

Objective(s):

- Identify those features unique to interdisciplinary education.
- Consider whether faculty development activities offered are interdisciplinary in nature based upon features identified.
- Discuss ways in which geriatric education centers could adapt multi-disciplinary learning programs to become more interdisciplinary in nature.

Presenter(s): Benjamin Liptzin, M.D., Director, Harvard GEC, facilitator
Wayne Bottom, P.A.-C., M.P.H., Univ. of Florida GEC
Nancy Ellis, Ph.D., O.T.R., Director, Delaware Valley GEC

The following summary was contributed to by **Dr. Benjamin Liptzin, Mr. Wayne Bottom and Dr. Nancy Ellis.**

The need for didactic as well as clinical experience was discussed in the context of including a cognitive base on group process, role conflicts, and affective components as revealed in the literature on developing health and interdisciplinary care teams. When two or more professionals worked with the same patient, there was a need for communication and collaboration skills designed to improve patient functioning. A consensus was reached that some mechanism should be found to develop case materials, teaching cases, annotated bibliographies, collections of articles on this topic that would be available to all GECs for use in all our educational programs. To assure that programs will be interdisciplinary, one should have multidisciplines in geriatric education.

Education and training should include didactic material, not just experimental material. Two resources were identified: a paper by David Thomasma entitled, "The Code of Ethics for Interdisciplinary Health Care," was distributed and the February 1987 issue of Clinics in Geriatrics was cited as having a number of articles on interdisciplinary care. Another resource for interdisciplinary education and service programs are the VA GRECCs which emphasize interdisciplinary team training. Finally, we should convince administrators and educators that interdisciplinary care is cost-effective and necessary for adequate patient care and thus should be taught to health professions students via effective role models.

Group C: Recruitment and Retention of Minorities in Geriatrics

Objective(s):

- Identify resources from which to recruit minority health professionals into geriatrics.
- Discuss issues and concerns considered important to minority involvement in geriatrics.
- Propose strategies to be considered by GECs interested in minority development activities in geriatrics.

Presenter(s): Rumaldo Juarez, Ph.D., Co-director, TCGEC, Facilitator
Madeline Goodman, Ph.D., Director, Pacific Islands GEC
Gwen Yeo, Ph.D., Director, Stanford GEC

Dr. Goodman stated Hawaii doesn't have a majority population; we have a huge diversity of minority. There are 26% white, 20% Japanese, 15% Chinese, 10% native Hawaiian, 15% Filipino and 5% other, i.e., Samoans, Vietnamese, and Koreans.

The University of Hawaii itself is extremely conscious of minority affairs. A principal task of the office of the academic vice president is to make sure that the issues are addressed in every single program on the campus; thus, in terms of the GEC it was a given that we would be addressing cross-cultural research and education issues because there's no other way in Hawaii.

In forming a center on aging, we put together a matching program in gerontology with a budget of approximately $200,000 as a base for gerontological education; with an expected supplement, a total of $500,000 in state funds will have been committed to aging, teaching, and research to match the GEC.

With regard to the specific issue of recruitment and retention of minorities, a program in the School of Medicine is unique in that it recruits Pacific Islanders to Honolulu. Thus, it's a foregone conclusion that Orientals and native Hawaiians will have access to our program. Also the MEDEX Program in the Pacific certifies health medical officers who are not physicians but have a five-year training program.

What we have done is link up with these outreach programs that we already have. It is very important to tailor our curricula to the needs of these island groups, and one can only do that by going out there and working for a period of time. It's very difficult when one person comes as a representative of an island nation to Hawaii to try and work on a one-to-one basis. It's more effective to send our people out there and have a more interactive kind of program and deal with issues in the field as they develop.

Our educational and research components should be more than superficial ones; we need to thoroughly understand the cultural dimensions and the cultural differences and the values of aging for these groups. What does it mean to be an older person who is Hawaiian compared to Vietnamese? Or what are the family structures? Answers to these questions will be sought by a very strong medical anthropology unit at the university and the GEC is being coordinated with this group.

We have many minorities in Hawaii working in geriatrics at a very low level. Many of them are refugees, Vietnamese, et al, who have had training in third-world countries and have been RNs or even physicians in Vietnam. These people are often working in nursing homes and long-term care units with our elderly. What we need to do is establish programs where they can recertify and go back to school without any loss of income.

Dr. Yeo commented that at Stanford, our special focus is on curriculum development and development of resources around a field we're calling ethno-geriatrics. Our emphasis is really on developing curriculum, doing review of the literature and providing expertise in areas where we can say something with authority about the need and the health attitudes and behaviors and the kinds of treatment modalities that differ by ethnicity in terms of older adults.

We do have a multidisciplinary, multi-cultural core faculty; we make a distinction between having minority representatives and being bilingual since we're also bi-cultural because it's very important for people to bring cultural perspectives in addition to a linguistic capacity when looking at ethnogerontological issues. Eight people represent disciplines, some of whom are from

Stanford, but because Stanford doesn't have a lot of the allied health professions, our core faculty also represents other schools in our three-zone target area: three are from San Jose State University--the dean of the school of social work, the chair of the OT department, a member of the nursing faculty, and three people are representatives of community college nursing programs. We also have physician assistants; altogether we have three Hispanics, three Blacks and one Asian on our core faculty.

Our faculty development program was not going to be a mini-fellowship or a long-term training activity. Rather, it was going to be one-shot conferences consisting of quarterly seminars and workshops. The first quarterly seminar was on the theoretical perspective of ethnicity in aging as it relates to health care. Interesting people came that we didn't expect to come. Once you identify yourself as being interested in an area, then people seek you out.

The primary care associates program based at Stanford is a combined community college and university program that trains physician assistants and nurse practitioners. It was established to meet the needs of medically underserved areas, attracting both minority faculty and students. Their enrollment of minority students went from 17% to 54% by changing some of their procedures. One change was going to communities, frequently rural communities. Students were trained in fairly short periods of time, e.g., they have preceptorships in their local communities where they can actually work with someone following a full-time quarter commitment. They went out to the community and came back to the university one week a month. They looked very hard for role models in faculty who could work with students in an ethnically sensitive way.

A really important point to make was that one can't just recruit faculty to teach a traditional curriculum that makes no effort to recognize the special needs of the populations providers will serve. The curriculum itself had to reflect the need for a multi-cultural background. Thus, the Stanford program has been successful as evidenced by having the fourth highest pass rate in the PA boards and yet they have the highest minority enrollment of any PA program outside of the traditional black schools that have PA programs. It's also important to mention the administrative stamp of approval.

Dr. Juarez said there is gross underrepresentation of minorities in gerontology in general and more specifically in geriatrics: As of this date in the United States, there are two Mexican/American geriatricians. One of them is in San Antonio, Texas, the other one is split between California and the Washington, D.C. area.

Based on observations made as a result of membership in the Association of Gerontology in Higher Education and the National Task Force on Minority Aging of the Gerontological Society of America, the concern for minorities turned out to be an ongoing one only to a very small core of people. So it was a problem, a generic problem of trying to get across the message to the gerontology community in general and geriatrics specifically that the growing numbers of minority elderly will present with very different types of needs.

What needs to be realized is that the circumstances and constraints might be different for those minority-aged populations than the older population at large. When it comes to the issues of recruitment and whether GECs concentrate on this issue in their own medical schools or institutions of higher education, a very limited pool of people will be found.

Regarding demographic changes in the minority population, the relationship between the young population of Hispanics and the aging white population in the United States was mentioned in the context of having a younger minority population being asked and expected to support programs for our white aging population. The next generation will be uneducated, will not have the kinds of occupations necessary to support the kinds of benefits that will be needed by the older population; to compound the issue it's also going to be a population that will not be able to take care of itself. Also, they are returning home as single parents with children to live with aging parents because they are in need of the extended family support economically.

If minorities are going to be involved in geriatric education centers, nontraditional sources of minorities, i.e., physicians and other professions already practicing in the community need to be brought in and utilized in some capacity to assist as educators of students in geriatrics.

Long-term funding was the major issue seen to be a mitigating factor affecting undergraduate recruitment of minorities in health professions in general and geriatrics in particular. Other recommendations Dr. Juarez made were as follows: 1. the need for curriculum modification to include minority aging content; 2. involve the minority community in developing GEC plans, goals and objectives; 3. all GECs incorporate minority recruitment and retention into their evaluation protocols; 4. include a cross-cultural emphasis in the 1989 annual GEC meeting; and 5. designate additional funds for GECs that serve significant proportions of minorities.

Remark from Audience: A faculty enrollee at Texas Tech in Lubbock has designed a course for one of the local schools composed primarily of Hispanic and Black students. In this magnet school program of the Lubbock Independent School District, there will be an elective course offered in geriatrics and gerontology to high school students.

Question from Audience: "Are there very many geriatric-specific recruitment materials targeted to minorities?" Dr. Juarez: "No. The only recruitment item that I am aware of is a video tape produced by the National Hispanic Council on Aging."

Group D: Clinical Experiences as Part of Faculty Development

Objective(s):

- Discuss the degree of clinical experiences that should be a part of faculty development activities offered by GECs.
- Explore whether there exists a core of experiential exercises in which faculty should be involved as part of the educational process.
- Identify ways in which these clinical experiences might be implemented.

Presenter(s): Jesley Ruff, D.D.S., Director, Midwest GEC, facilitator
Pat Blanchette, M.D., Executive Director Pacific Islands GEC
James O'Brien, M.D., Director, GEC of Michigan

Drs. Jesley Ruff, Pat Blanchette, and James O'Brien jointly contributed to the following summary of their session.

Discussions centered on the three aspects of the topic: the degree of clinical experiences that should be part of faculty development activities offered by GECs; development of a core of experiential exercises in which faculty should be involved as part of the educational process; and identification of ways in which these clinical experiences might be implemented.

The importance of including clinical experiences as part of faculty development was unanimously agreed upon; however, a distinction should be made between the individuals that are coming into the GECs as trainees based on their previous backgrounds. Regardless of differences in faculty experience, few have had interdisciplinary training; thus, one of the points made was that full-time faculty people bring their own patients for a team assessment that would demonstrate an interdisciplinary approach.

The second discussion explored whether there exists a core of experiential exercises in which faculty should be involved as part of the educational process. It became apparent that one has to deal with recruitment and the types of individuals that come into the experiences and what their previous backgrounds are. The level of competence these individuals come in with was also discussed. Thus, it becomes important in developing a core curriculum that individual differences be taken into account. In implementing clinical experiences, it is important to match the individual trainees' needs with the resources available to the GEC. Also, an important point was made that clinical experiences are very labor intensive.

Group E: Approaches to Resolving Unanticipated Problems

Objective(s):

- **Query participants regarding the nature of unanticipated problems encountered since establishment of their GEC.**
- **Explore the context from which unanticipated problems emerged.**
- **Identify strategies GECs use to resolve unanticipated problems.**

Presenter(s): Robert Wallace, M.D., Iowa GEC, facilitator
Elizabeth King, Ph.D., GEC of Michigan
Barbara Palmisano, M.A., R.N., Western Reserve GEC

Dr. Robert Wallace, Dr. Elizabeth King, and Ms. Barbara Palmisano each contributed to the following summary of this session.

A question was raised by a representative from the Pacific Islands GEC regarding working with lower-level professionals and high school educated persons in third-world type territories under their purview.

Dr. Wallace responded that, based on his own experiences, the third world is yet to be convinced that aging is a problem given the magnitude of other problems that they face. A suggestion was made to establish some kind of dialogue to get them to tell you basically what are their perceived educational needs.

When a center is brand new, the Iowa GEC used a similar strategy--tap into existing organizations to use some of their communication linkages, i.e., their newsletters and other things like that that have feature articles to communicate about GEC sessions that are planned or solicit information by incorporating a questionnaire about readers' needs or interests.

Another question raised dealt with ethnic issues, specifically about including folk healers in the total context of care for elderly persons who are culturally predisposed to give credence to folk healers.

A comment from an individual at the GEC of Michigan, Eastern Michigan University, focused on the issue of cultural sensitivity in terms of service delivery for older people and their expertise with Blacks, Hispanics, and Arabic-speaking cultures in the Detroit metropolitan area.

Dr. Wallace pointed out that while everyone in attendance would be in favor of cultural sensitivity, how are GECs supposed to be teaching teachers and promoting geriatric education that will be self-sustaining. Ergo, the question, "Do you involve folk healers, do you train them, do you train folk healers who may be within their own cultural communities and who are going to train other people?" One suggestion was to query GECs such as Puerto Rico who deal with predominant groups associated with folk healers, i.e., Hispanics.

A question was raised regarding how to deal with a new identity and receive appropriate recognition. One suggestion was to get on state committees and units on aging to build a state network of geriatric educators and practitioners.

Dr. Wallace responded by pointing out that in a tertiary medical center one of the problems for the Iowa group has been that there are numerous other centers that basically are trying to do the same thing: everyone wants to network in the community, to organize community practitioners, and while none object to the others, there is, nevertheless, competition for a limited amount of public consciousness, space, and university resources.

One suggestion was to identify faculty of strong departments and market oneself as a non-competitive entity by complementing what that faculty group wants to do.

A question was raised regarding how one feels about being properly recognized. Regarding equality among colleagues at other institutions or in other departments on campus or with other disciplines, the question is: "Is it really a partnership or a consortium when one institution is a fiscal agent and controls major issues?"
The suggestion made was to be conscious of the control issue. Some successful techniques have been when programs are planned to go to such lengths as to microwave a teleconference for the planning committee so that no favoritism is shown as to where the committee meeting is being held; be sure to plan the committee very carefully with respect to disciplines and representation of institutions; and be careful who the faculty is, that each institution is represented by faculty, who gives the welcome, and rotate sites.

Title: PLENARY SESSION PANEL DISCUSSION: "The Role of GECs in Community Development"

Objective(s):

- Describe ways in which GECs currently contribute to the communities which they serve.
- Consider whether the GEC is viewed as a resource vital to community planning.
- Explore various ways in which GECs might facilitate planning for community services to older individuals.
- Discuss whether centers have a responsibility to the community in this regard.

Presenter(s): Linda Brasfield, M.S., Co-director, OVAR GEC
David Haber, Ph.D., Creighton Regional GEC
Eric Rankin, Ph.D., Great Lakes GEC
Carlos Gonzalez Oppenheimer, M.D., GEC of Puerto Rico

The following summary was contributed to by Ms. Linda Brasfield, Dr. David Haber, Dr. Eric Rankin, and Dr. Carlos Oppenheimer.

Current Contributions to Community Activities

The activities of most, if not all, geriatric education centers currently revolve around faculty development, curriculum planning, clinical coordination and information exchange. The time-consuming nature of these undertakings are such that center faculty and staff have little left in the way of energy, time or resources for community development. This in no way is meant to de-emphasize the importance of the general public or consumer groups. Clearly, geriatric education center representatives recognize that the ultimate beneficiaries of the educational experiences offered will be the older person and the community in which they reside.

While concerned about the community issues, it was apparent that enrollees in GEC-sponsored program offerings have a limited understanding of the aging network--those important community agencies providing services outside the university, the hospital and the nursing home. The body of knowledge regarding area agencies, departments of aging, provider agencies affiliated with the network, voluntary organizations, etc. is quite large and immensely important to the care of older persons. In an effort to address the limited understanding in this area exhibited by both faculty and practitioners, some GECs have sought to involve network representatives in GEC programs and distribute printed materials appropriate to the needs of specific disciplines during center-sponsored activities.

Faculty and practitioners in health-related disciplines must likewise be taught how to work with the older family member of a frail person and the children of elderly parents who are the full-time care givers. There also appeared to be an insufficient understanding of the extensive roles played by self-help groups in addressing many of the chronic illnesses and problems of concern within the field of geriatrics. Studies in New York likewise indicated that even social workers were unfamiliar with this important community activity. Programs should therefore begin providing experiences in how to work with these self-help groups. Approached in this fashion providers and faculty educators would be better prepared to add to the expertise and resources of the self-help groups and the communities in which they reside.

Community Planning Resource

Throughout the duration of the workshop there have been numerous examples presented depicting the ability of geriatric education centers to mobilize resources in response to genuine requests for technical assistance. Less frequently heard were instances of conflict experienced when interfacing with various groups already in the aging network. To address issues of competition, centers should explore the use of broad-based planning committees for proposed center programs. In this way, concerned factions could engage in relentless self-promotion while contributing effectively to the design and implementation of community-based programs.

Other mechanisms to consider relative to having others view the GEC as a valuable resource for planning include finding out what other major geriatric grants and contracts are underway about the state and offering to work with them, providing speakers on topics of interest to groups and agencies, and encouraging major care provider organizations to become sponsors of GEC activities. The latter mechanism assumes venturing into the community, the results of which will be increased visibility of the geriatric education center.

Approaches Used to Facilitate Planning

A variety of strategies exist for use in planning for community services. Indirect methods involve using community health professions on interdisciplinary teams designed to develop the clinical assessment skills of students. Using case studies, the practitioners become involved in the learning activity and the quality of care provided in the facility can be improved. On a more overt level, one can utilize planning strategies designed to assess perceived needs or collaborate with community agencies to provide in-home evaluation services. These joint ventures often lead to greater student training in community settings and the development of trust, an essential ingredient for further community-oriented services.

Specific examples of outreach activities designed to develop community ties include speakers bureaus, in-service programs, area health education center-sponsored programs, and targeted workshops focusing on issues and concerns of elderly individuals. Logistics are also important as community-based providers of all types are restricted in terms of the blocks of time that can be devoted to personal development. When programs are given in the evening or on weekends, the presenters should be local specialists upon which the community can rely when program activities are complete.

Title: CLOSING PLENARY PANEL SESSION: "Future Directions for Geriatric Education Centers"

Objective(s):

- Comment on the original goals associated with the implementation of GEC.
- Describe the planning and assessment methods directed at the attainment of the original goals.
- Discuss those enabling and constraining factors that impacted on the programmatic activities of the center.
- Consider ways in which the information-transfer role of GECs might be altered in the future.

Presenter(s): Evan Calkins, M.D., Director, Western New York GEC, SUNY Buffalo, Chair
John Beck, M.D., Director, California GEC
Jerome Kowal, M.D., Director, Western Reserve GEC
Terry Fulmer, RN, PhD, Columbia University

The chair expressed his gratitude to the Houston hosts and to the Bureau of Health Professions for having made the workshop an outstanding event, then introduced the panel whose comments follow.

Dr. Beck, as representative of a new GEC, said that he hoped none of his remarks would be misconstrued and that his observations on the subject of the session were obviously based on his personal experience in terms of medicine, but were ones that would be equally held by the other health professions. Dr. Beck's observations were based on the outcome of the effort in which primarily internal medicine, family medicine, and psychiatry have been attempting to produce academic leaders in geriatrics. He then talked about the dilemma we face.

HRSA has been engaged in providing resources for the training and health care efforts of the whole series of health professionals interested in geriatrics. The GEC program has emphasized resource development, multidisciplinary training of faculty, and CME for practitioners rather than the production of geriatric leaders, although many geriatric leaders from a variety of health disciplines have played an important role as project directors in the GEC programs. GECs have provided health faculty personnel and professionals in the field with a comprehensive range of geriatrics in terms of logical educational resources in a variety of settings, and has filled in some of the gaps which existed in federal programs supporting the development of professionals to care for America's aging population. At this point in time, however, we should begin to assess where we've been and where we're going in terms of our training of academic leaders in medicine and for other health disciplines.

As of 1986, 413 fellows were identified as having been trained in this country in geriatric medicine (including family practice) or geropsychiatry. These individuals and their program directors responded to a survey instrument. In light of the major objective being development of academic leadership in the field, these data were presented: Of 413 fellows, 375 responded (284 were in geriatric medicine and 91 in geropsychiatry), a response rate of 80% in medicine and 65% in geropsychiatry; only 64% of respondents had trained for two or more years in geriatrics; in geropsychiatry, 64% of the faculty had only one year of training; of the geriatric medicine fellows, 22% did absolutely no teaching and 65% of the group spent 10% or less of their time in teaching; 44% of the fellows in geriatric medicine were doing no research, no scholarly activity; 67% of the researchers were spending 10% or less of their time in research; 44% of the geriatric medicine fellows were spending greater than 50% of their time in clinical care; and 61% spent 10% or less of their time in a long-term care institutional setting.

Those who have produced academic leaders in a variety of other fields over the last decade look upon these data in a very sobering fashion. Now that raises the dilemma about a profound shortage, a national crisis in adequately prepared faculty in all health professional schools coupled with an environment which has a shortage of resources. How do we deal with the problem? The issue, which a number of colleagues from Washington have brought up, is whether one diffuses scarce resources over a wide population or whether at this particular stage in our nation one attempts to focus the resources on a limited number of centers, i.e., centers of excellence. Answers to these three questions must be sought: How can we best and most efficiently train academic leaders in the health professions? How are we going to attract the most highly qualified applicants? How are we to adequately and stably fund these individuals after they have completed their training and place them in an environment with respect to their academic leadership roles.

Regarding the centers of excellence suggestion, oncology was used as a field that had many of the same problems that presently confront geriatrics except that there was in oncology a major clinical data base. However, there was in oncology a need for not only academic leadership, including research ranging from bench research to health services research, but there was also a need to develop new systems of care for individuals with neoplasia. A war on cancer was declared by President Nixon and the field of oncology changed dramatically: Suddenly, professionals developed a major interest in it; major research was fostered and emerging academic leadership resulted in oncology becoming mainstreamed into the health professions concerned with teaching and caring for all persons with cancer. While one can conjecture a number of reasons why this transformation occurred, the answer was probably because the major funding oncology received led to the mainstreaming effort.

In closing, the data shared, which were very superficial in terms of numbers, raised the issue of whether or not we're in danger of producing superficiality in the health professions in terms of their knowledge, skills and scholarly activity in geriatrics.

Dr. Kowal described his own transition from a decade of experience as Chief of Staff at the Veterans Administration to taking a six-month sabbatical in geriatrics at UCLA four years ago, Dr. Kowal concurred with what Dr. Beck said about recruiting people who need to be stimulated, trained, and then placed in the right part of the country to continue the effort.

Dr. Kowal expressed gratitude for the GEC program for having helped establish the credibility of their program in Cleveland. This resulted in geriatrics being so well established on the Case Western campus that for the first time the handbook that's published for prospective medical students included an entire page in which the GEC is described as a major component of the medical school.

Regarding the future of GECs, initiatives in programmatic assessment that Dr. Richard Hubbard, Program Director, have been working on will help us perpetuate the programs. In our program, emphasis has not only been placed on the process of getting the programs going and getting the people involved but also on looking at mechanisms of showing that there is a product, i.e., objective figures can be shown.

An analogy between the GEC program and the Veterans Administration is that the Veterans Administration Hospitals operate under the same rules and regulations across the country. However, no two VA hospitals are alike; each one has the flavor of its own institution in its own locale. Ergo, the truth of the matter is that one can't judge from what has been done at Case Western, for example, and compare it with other institutions.

Case Western is now looking at criteria for inclusion of disciplines; four criteria may be of importance to future GECs. These are (1) manpower needs and objectives for each discipline (A caveat is that there aren't too many faculty who have a whole year to give to the program, thus one has to set up flexible arrangements.); (2) relevance of the discipline to aging; (3) the potential role of the discipline in interdisciplinary programs; and finally, (4) the degree of institutional commitment that exists.

Although we're all very different in terms of how we do things and the kinds of things that we do and the kinds of people that we reach, the one thing that needs to be done regarding meeting our future goals is to define a unifying theme that can be presented to the health professions at large.

Next, we need to be sure that we are establishing ourselves in our local areas as entities that people want to see continue to exist. This raises the issue of continued stable funding. After five years of funding, perhaps an institution could apply for a matching program whereby the government would offer X number of dollars which would be matched by local resources, thus providing a floor on funding but with a commitment from the local people that they really want this effort to continue.

The importance of tracking was mentioned again. Keeping a record of the GEC's growth and development in terms of the number of disciplines involved, the number of academic institutions, the number of clinical institutions, the number of completed enrollees, and the number of training hours provided per year constitutes a quantitative measure of what we're doing in addition to the qualitative measure of what we're doing.

Dr. Fulmer spends eighty percent of her time in nursing research as a certified gerontological nurse specialist, having sat for the American Nurses Association Certification Exam in 1979. She has served as the Associate Director of the Harvard Geriatric Education Center from 1983 to 1987 and is currently associated with the Hunter/Mt. Sinai Geriatric Education Center.

Dr. Fulmer's comment about the mission of GECs and evidence of the attainment of that mission was that in 1983 the guidelines for the GEC grant application stipulated that geriatric education centers would be interdisciplinary; 31 GECs at this meeting attest that much has been accomplished to that end and this behavior would have moved at a dramatically slower pace without the GEC initiative, a phenomena to be touted.

Regarding the future and information transfer, in a world of burgeoning data and journals, the challenge to all of us is to develop new methods of communication, e.g., newsletters, electronic bulletin boards, and creative computer linkages.

Regarding institutionalization of centers, while GECs are now in numerous health science campuses, it isn't easy to maintain a foothold in the mainstream of our respective campuses. Thus, we must have organized mechanisms to achieve that end.

A final point relates to the body of leadership that has sprung from this initiative. For many of us, this GEC initiative has provided the vehicle for improving our own gerontological credentials.

Dr. Calkins addressed the future direction of GECs within the context of what to do when one is not refunded, the normal reaction of disappointment, even anger, was acknowledged. For those in the group here who weren't refunded, Dr. Calkins recited an old poem to assuage their feelings: "Much of life is trial and trouble, two things stand like stone: friendship and another's trouble and encouraging one's own."

The next step is to think through whether your GEC really should have applied to that particular program in the first place. There are lots of avenues for funding. Did your GEC happen to pick the right one on that particular occasion? Here's the sort of questions that one might ask: As a Program Director, was that particular program really consistent with our goals, our top priorities? And do you think that direction is really important for the future of medicine?

Next, stick to those goals through good times and bad. It's very important to stick with those goals and think very carefully before shifting directions in response to the latest message from Washington.

Determine what went wrong by reviewing the pink sheets and talking to successful applicants. Having a consultant or advisory committee is a good one.

After determining that your goals are right, that you're determined to make it, then it's just a matter of keeping things going. However, one has to be careful not to make a rash commitment to too many activities that may prove to be inconsistent with one's long-term goals. It's important to be generous enough to help others in the community and the university by marshalling the resources at one's disposal. Using the principle of resource exchange, i.e., in an era of limited resources, and by pooling resources that are already committed and supplementing each other in effective ways, one can often do just as well or better than relying on external funding.*

---

*This narrative concludes the final report of the Fourth Workshop for Key Staff of Geriatric Education Centers held April 21-24, 1988 in Houston, Texas.

V. FOURTH GEC WORKSHOP FOR KEY STAFF

Participant List

April 21 - 24, 1988

Participant List

Itamar Abrass, M.D.
Director
Northwest GEC
Harborview Medical Center (ZA87)
325 Ninth Avenue
Seattle, Washington 98104
(206) 223-3089

Patricia H. Andrews, Ph.D.
Program Coordinator
Iowa GEC
E418GH, The University of Iowa
Iowa City, IA 52242
(319) 356-1073

Eugene Barone, M.D.
Project Director
Creighton Regional GEC
601 N. 30th, Suite 3M 30
Omaha, Nebraska 68178
(402) 280-4175

Gloria Barry, R.N., Ph.D.
Director, Educational Programs
GEC of Pennsylvania
Temple University - IOA
1601 North Broad Street
Philadelphia, PA 19122
(215) 787-6970

John Beck, M.D.
California GEC
UCLA School of Medicine
10833 Le Conte Avenue (CHS)
Los Angeles, CA 90024-1686
(213) 825-8255

Judith Bell, Ed.D.
Program Director
Creighton Regional GEC
112 Applewood Mall, The Center Mall
42nd and Center Streets
Omaha, Nebraska 68105
(402) 341-9212

Richard Besdine, M.D.
Director
Univ. of Connecticut GEC
Travelers Center on Aging
Univ. of Connecticut Health
Science Center
Farmington, CT 06034
(203) 679-3956

Patricia L. Blanchette, M.D., M.P.H.
Executive Director
Pacific Islands GEC
347 North Kuakini Street
Honolulu, Hawaii 96817
(808) 523-8461

Wayne Bottom, PA-C, MPH
University of Florida GEC
College of Health Related Professions
Box J-176, JHMHC
Gainesville, Florida 32610
(904) 392-4326

Paula G. Boyum, Ph.D.
Faculty Development Coordinator
Great Lakes GEC
Chicago College of Osteopathic Med.
5300 S. Ellis Avenue
Chicago, Illinois 60615
(312) 947-4867

Linda Brasfield, M.S.
Co-Director
Ohio Valley Appalachia Regional GEC
20 Chandler Medical Center Annex I
University of Kentucky
Lexington, KY 40536-0079
(606) 233-6040/5156

Rick Briggs, M.A.
Institutional Representative
Ohio Valley Appalachia Regional GEC
Gerontology Center
West Virginia University
Chestnut Ridge Prof. Bldg. #12
Morgantown, WV 26506
(304) 293-2081

Evan Calkins, M.D.
Director
Western New York GEC
3435 Main Street, Beck Hall
State University of New York
Buffalo, NY 14214
(716) 831-3176

Roy Campbell, R.N., M.S.
Staff Core
Stanford GEC
703 Welch Road, Suite H-1
Stanford, CA 94305
(415) 725-4489

George Caranasos, M.D.
Director
University of Florida GEC
Box J-277, JHMHC
University of Florida
Gainesville, Florida 32610
(904) 392-3197

J. Richard Connelly, Ph.D.
Education Coordinator
Intermountain West GEC
University of Utah
25 South Medical Drive
Salt Lake City, Utah 84112
(801) 581-8198

Linda J. Davis, Ph.D., O.T.R.
Director
Pacific Geriatric Education Center
University of Southern California
1975 Zonal Avenue, KAM 300-C
Los Angeles, CA 90033
(213) 224-7994

Jeffrey Delafuente, M.S.
Program Director
University of Florida GEC
College of Pharmacy
Box J-486, JHMHC
University of Florida
Gainesville, Florida 32610
(904) 392-3155

Margaret Dimond, R.N., Ph.D.
Project Director
Intermountain West GEC
University of Utah
25 South Medical Drive
Salt Lake City, Utah 84112
(801) 581-8198

Rose Dobrof, D.S.W.
Co-Director
Hunter/Mount Sinai GEC
Brookdale Center on Aging
425 East 25th Street
New York City, New York 10010
(212) 481-4417

Peggy Edson, M.S.N.
Asst. Director for Nursing
Harvard GEC
Division of Aging
Harvard Medical School
643 Huntington Avenue
Boston, MA 02115
(617) 732-6844

Nancy Ellis, Ph.D., O.T.R.
Co-Director
Delaware Valley GEC
3906 Spruce Street
Philadelphia, PA 19104
(215) 898-3174/8088

Molly Engle, Ph.D.
Evaluation Specialist/Program Dir.
University of Alabama GEC
UAB/Educational Development
CHSB Room 401, University Station
Birmingham, Alabama 35294
(205) 934-3686

Diana Fabacher, M.S.P.H.
Asst. Director, Program Development
and Evaluation
Mississippi GEC
University of Mississippi
Alumni House, Room #319
2500 North State Street
Jackson, Mississippi 39216
(601) 984-6190/6191

Carl Fasser, B.S., P.A.-C.
Co-Director, Faculty Development
Texas Consortium of GECs
Baylor College of Medicine
One Baylor Plaza, Room 231E
Houston, Texas 77030
(713) 799-4619

John Feather, Ph.D.
Associate Director
Western New York GEC
3435 Main Street, Beck Hall
State University of New York
Buffalo, NY 14214
(716) 831-3176

Ruth A. Freiburger, M.A.
Educational Specialist
South Texas GEC
Dept. of Dental Diagnostic Science
University of Texas Health Science
Center at San Antonio
7703 Floyd Curl Drive
San Antonio, Texas 78284-7919
(512) 567-3370

Terry Fulmer, R.N., Ph.D.
Columbia Univ., City of New York
School of Nursing
630 West 168th Street
New York, NY 10032
(212) 305-3198

Davis L. Gardner, M.A.
Co-Director
Ohio Valley Appalachia Regional GEC
20 Chandler Medical Center Annex 1
University of Kentucky
Lexington, KY 40536-0079
(606) 257-5431

Carol Gleich, Ph.D.
Coordinator, GEC Program
DADHP, Bureau of Health Professions
Parklawn Building, Room 8-103
5600 Fishers Lane
Rockville, MD 20857
(301) 443-6887

Carlos Gonzalez Oppenheimer, M.D.
Medical Director
University of Puerto Rico GEC
GPO Box 5067
San Juan, Puerto Rico 00936
(809) 751- 2478

Gerald Goodenough, M.D.
Co-Project Director
Intermountain West GEC
Univ. of Utah, School of Medicine
Dept. of Family and Preventative
Medicine
Room 1C377
Salt Lake City, Utah 84123
(801) 581-7234/8634

Madeleine Goodman, Ph.D.
Principal Investigator
Pacific Islands GEC
347 North Kuakini Street
Honolulu, Hawaii 96817
(808) 948-8445/523-8461

Lynn Groth, M.S.
Director, Dakota Plains GEC
Dept. of Family Medicine
University of North Dakota
Grand Forks, N.D. 58201
(701) 777-3200

Marita Grudzen, M.H.S.
Coordinator
Stanford GEC
703 Welch Road, Suite H-1
Stanford, CA 94305
(415) 723-7063

David Haber, Ph.D.
Associate Project Director
Creighton Regional GEC
112 Applewood Mall, Center Mall
42nd and Center Streets
Omaha, NE 68105
(402) 280-4175

Thomas D. Hatch
Associate Administrator for
Policy Coordination
Health Resources and Service Admin.
Parklawn Building, Room 14-05
5600 Fishers Lane
Rockville, MD 20857
(301) 443-2033

Neil Henderson, Ph.D.
Project Coordinator
University of South Florida GEC
USF, Medical Center, Box 50
12901 N. 30th Street
Tampa, Florida 33612
(813) 974-4355

Mary Anne Hilker, Ph.D.
Associate Director
University of Florida GEC
Box J-277, JHMHC
University of Florida
Gainesville, FL 32610
(904) 376-1611, Ext. 5027

Barbara Horn, Ph.D.
Program Coordinator
School of Nursing
Northwest GEC
3935 University Way NE
Seattle, WA 98195
(206) 545-7478/0850

Richard Hubbard, Ph.D.
Program Director
Western Reserve GEC
School of Medicine
Case Western Reserve University
Cleveland, Ohio 44106
(216) 368-5433/844-7246

Glenn H. Hughes, Ph.D.
Center Director
University of Alabama GEC
Medical Towers Room 731
1717 11th Avenue South
Birmingham, AL 35205
(205) 934-1094

Stanley R. Ingman, Ph.D.
Project Management Team
Missouri GEC
Dept. of Family & Community Medicine
Medical Science Building
University of Missouri - Columbia
Columbia, Missouri 65211
(314) 882-5609/6011

Clayton E. Jensen, M.D.
Chairman, Dakota Plains GEC
Dept. of Family Medicine
University School of Medicine
501 Columbia Road
Grand Forks, ND 58201
(701) 777-3264

Robert T. Jensen, M.D.
GEC Executive Committee
South Texas GEC
Department of Family Practice
University of Texas Health Science
Center at San Antonio
7703 Floyd Curl Drive
San Antonio, TX 78284
(512) 567-3370

Arleen Johnson, M.S.W., Ph.D.
Project Manager
Ohio Valley Appalachia Regional GEC
20 Chandler Medical Center Annex 1
University of Kentucky
Lexington, KY 40536-0079
(606) 233-5135/5156

Rumaldo Z. Juarez, Ph.D.
Co-Project Director
Texas Consortium of GECs
Department of Sociology
Pan American University
Edinburg, TX 78539
(512) 381-2300

Jurgis Karuza, Jr., Ph.D.
Asst. Director for Evaluation
and Research
Western New York GEC
State University of New York
3435 Main Street, Beck Hall
Buffalo, NY 14214
(716) 831-3176

Marie L. Koch, M.S., P.T.
Co-Project Director
Texas Consortium of GECs
School of Allied Health, Dept. of
Physical Therapy
Texas Tech University Health
Sciences Center
Lubbock, TX 79430
(806) 743-3229

William Koenig, M.P.A.
Deputy Chief
Associated and Dental Health
Professions
DADHP, Bureau of Health Professions
Parklawn Building, Room 8-103
5600 Fishers Lane
Rockville, MD 20857
(301) 443-6887

Marianne Koeppel, M.S.
Program Coordinator
Western New York GEC
State University of New York
3435 Main Street, Beck Hall
Buffalo, NY 14214
(716) 831-3176

Jerome Kowal, M.D.
Director, Western Reserve GEC
Geriatric CARE Center
2074 Abington Road
University Hospitals of Cleveland
Cleveland, Ohio 44106
(216) 844-7246

Karen Krall-Murphy, M.S.N., G.N.P.
Curriculum Coordinator
Creighton Regional GEC
112 Applewood Mall, Center Mall
42nd and Center Streets
Omaha, NE 68105
(402) 341-1197

Steven Krantz, Ph.D.
Project Management Team
Missouri GEC
2220 Holmes
Kansas City, MO 64108
(816) 276-1711

Lisa Leonard, Ph.D.
Co-Project Director
Texas Consortium of GECs
Office of Curricular Affairs
School of Allied Health Sciences
University of Texas Medical Branch
Galveston, TX 77550
(409) 761-3020

Benjamin Liptzin, M.D.
Harvard GEC
643 Huntington Avenue
Boston, MA 02115
(617) 732-1463

Donald M. Loppnow, M.S.W.
Co-Director
GEC of Michigan
411 King Hall
Eastern Michigan University
Ypsilanti, Michigan 48197
(313) 487-0393

Sasha Loring, M.A.
Education Consultant
University of North Carolina GEC
Dept. of Medicine, CB 7110, 3
5039 Old Clinic Bldg. 226H
Chapel Hill, NC 27599
(919) 966-2276

Thomas Louden, D.D.S.
Director
Division of Associated and Dental
Health Professions
DADHP, Bureau of Health Professions
Parklawn Building, Room 8-101
5600 Fishers Lane
Rockville, MD 20857
(301) 443-6853

Robert Luchi, M.D.
Co-Project Director
Texas Consortium of GECs
Medical Service, 111
Houston Veteran's Administration
Medical Center
Houston, TX 77211
(713) 795-7425

Dale Lund, Ph.D.
Evaluation Specialist
Intermountain West GEC
University of Utah
25 South Medical Drive
Salt Lake City, Utah 84112
(801) 581-8198

Charles R. Lyden, M.P.H., M.B.A.
Assistant Director
Pacific Islands GEC
347 North Kuakini Street
Honolulu, Hawaii 96817
(808) 523-8461

Cindy MacQuarrie, R.N., M.N.,C.
Project Management Team
Missouri GEC
UMKC School of Nursing
2220 Holmes
Kansas City, MO 64108
(816) 276-1704

George Magner, Ph.D.
Co-Project Director
Texas Consortium of GECs
Graduate School of Social Work
University of Houston - Univ. Park
4800 Calhoun
Houston, TX 77004
(713) 749-1741

Carolyn E. Marshall, M.P.H.
Community Education Coordinator
South Texas GEC
Dept. of Dental Diagnostic Science
University of Texas Health Science
Center at San Antonio
7703 Floyd Curl Drive
San Antonio, TX 78284-7919
(512) 567-3370

Thomas D. Marshall, D.D.S.
Executive Committee
South Texas GEC
Dept. of Restorative Dentistry
University of Texas Health Science
Center at San Antonio
7703 Floyd Curl Drive
San Antonio, TX 78284
(512) 567-3688/3370

Laura J. Mathew, R.N., M.P.H.
Clinical Instructor
University of North Carolina GEC
Campus Box 7595
University of North Carolina
Chapel Hill, N.C. 27599
(919) 966-3385

Sherry A. McDonnell
Workshop Staff
Texas Consortium of GECs
Baylor College of Medicine
One Baylor Plaza, Room 134-A
Houston, TX 77030
(713) 799-6470

Constance M. McGarry, M.S., R.N.
Coordinator of Information Services
Delaware Valley GEC
University of Pennsylvania
3906 Spruce Street
Philadelphia, PA 19104
(215) 898-3174

Hermine E. McLeran, M.P.H.
Educational Coordinator
Iowa GEC
Aging Studies Program
415JB, The University of Iowa
Iowa City, Iowa 52242
(319) 335-3822

Robin H. McMahon, M.S.
Teleconference Coordinator
Virginia Commonwealth Univ. GEC
Box 228 MCV Station
Richmond, VA 23298-0228
(804) 225-4101

Joanna Mellor, M.S.
Coordinator
Hunter/Mount Sinai GEC
Brookdale Health Service Center
425 East 25th Street
New York, New York 10010
(212) 481-5142

Jennifer Mendez, Ph.D.
Director, Resource Center
Midwest GEC
604 North 16th Street
Milwaukee, Wisconsin 53233
(414) 224-3709

Susan L. Mitchell, M.A.
Instructional Design Specialist
Iowa GEC
Office of Consulting and Research
in Medical Education
2361-C SB, The University of Iowa
Iowa City, IA 52242
(319) 335-8901

Lucille Nahemow, Ph.D.
Director
University of Connecticut GEC
Travelers Center on Aging
University Branch
University of Connecticut, U-58
Storrs, CT 06268
(203) 486-4043

Gary M. Nelson, D.S.W.
GEC Coordinator - Social Work
University of North Carolina GEC
223 E. Franklin Street, 150A
Chapel Hill, NC 27514
(919) 962-1225

Richardson K. Noback, M.D.
Principal Investigator
Missouri GEC
UMKC School of Medicine
2411 Holmes
Kansas City, MO 64108
(816) 276-1953

James O'Brien, M.D.
Director, GEC of Michigan
B544 West Fee Hall
Michigan State University
East Lansing, MI 48824-1316
(517) 353-7780/377-0330

Rosemary Orgren, Ph.D.
Project Director
California GEC
Preventive Medicine and Public Health
Department of Community Health
TB168
University of California
Davis, CA 95616
(916) 752-6114

Barbara Palmisano, R.N., M.A.
Regional Coordinator
Western Reserve GEC
Northeastern Ohio Universities College of Medicine
Rootstown, Ohio 44272
(216) 579-1181

Joseph A. Papsidero, Ph.D.
Co-Director
GEC of Michigan
B545 West Fee Hall
Michigan State University
East Lansing, Michigan 48824
(517) 353-3990

Celia Pedrosa-Garcia, PA-C
Core Faculty Member
Stanford GEC
703 Welch Road, Suite H-1
Stanford, CA 94305
(415) 723-7063

Eric Pfeiffer, M.D.
Director
University of South Florida GEC
USF, Medical Center, Box 50
12901 N. 30th Street
Tampa, Florida 33612
(813) 974-4355

Joy Plein, Ph.D., R.Pharm.
Program Coordinator
School of Nursing
Northwest GEC
3935 University Way NE
Seattle, WA 98195
(206) 545-7478/543-2041

Eileen Poiley, M.S.
Assistant Project Coordinator
University of South Florida GEC
USF, Medical Center, Box 50
12901 N. 30th Street
Tampa, Florida 33612
(813) 974-4355

Carmen Porrata Colon, R.N., M.S.N.
Faculty & Clinical Coordinator
University of Puerto Rico GEC
GPO Box 5067
San Juan, Puerto Rico 00936
(809) 751-2478

Joyce Prothero, Ph.D.
Deputy Director, Northwest GEC
University of Washington JM-20
Seattle, WA 98195
(206) 545-7478

Eric Rankin, Ph.D.
Program Director, Great Lakes GEC
Chicago Osteopathic Medical Center
Room 5120
5300 South Ellis Ave.
Chicago, IL 60615
(312) 947-4867

Robert E. Roush, Ed.D., M.P.H.
Project Director
Texas Consortium of GECs
Baylor College of Medicine
One Baylor Plaza, Room 134A
Houston, TX 77030
(713) 799-4611

Jesley C. Ruff, D.D.S.
Program Director, Midwest GEC
Marquette University
604 North 16th Street
Milwaukee, WI 53233
(414) 224-3712

Elizabeth Sanchez, Ph.D.
Director
University of Puerto Rico
GPO Box 5067
San Juan, Puerto Rico 00936
(809) 751-2478

Michele Saunders, DMD, MS, MPH
Director
South Texas GEC
University of Texas Health Science
Center at San Antonio
Dept. of Dental Diagnostic Science
7703 Floyd Curl Drive
San Antonio, Texas 78284-7919
(512) 567-3370

Richard Schulz, Ph.D.
Co-Director
GEC of Pennsylvania
University of Pittsburgh
1617 Cathedral of Learning
Pittsburgh, PA 15260
(412) 624-2311

Elizabeth Oates Schuster, M.A.
Project Manager
GEC of Michigan
411 King Hall
Eastern Michigan University
Ypsilanti, Michigan 48197
(313) 487-0393

Veronica Scott, M.D., M.P.H.
Director, Center on Aging
University of Alabama GEC
Meharry Medical College
1005 D.B. Todd, Jr. Boulevard
Nashville, TN 37208
(205) 933-8101

Kathleen Segrist, M.Ed.
Program Coordinator
GEC of Pennsylvania
Temple University - IOA
1601 North Broad Street
Philadelphia, PA 19122
(215) 787-6970

Judith Sellers, DN.Sc.
Associate Director
University of Connecticut GEC
University of Connecticut
348 Mansfield Road, Box U-58
Storrs, CT 06268
(203) 486-4729

Mona L. Shilling
Administrative Secretary III
Dakota Plains GEC
University of North Dakota
School of Medicine
Dept. of Family Medicine
501 Columbia Road
Grand Forks, ND 58201
(701) 777-3214

Deborah Simpson, Ph.D.
Director, Educational Services
Midwest GEC
Medical College of Wisconsin
8701 Watertown Plank Road
Milwaukee, WI 53226
(414) 257-8581/8207

Ted Sparling, Dr.P.H.
Co-Project Director
Texas Consortium of GECs
Dept. of Health Administration
Trinity University
715 Stadium Drive
San Antonio, TX 78284
(512) 736-8107

Mark Stratton, Pharm.D.
Project Director
New Mexico GEC
Room 719A, Nursing/Pharmacy Bldg.
University of New Mexico
Albuquerque, NM 87131
(505) 277-5134

Neville Strumpf, R.N., Ph.D.
Director of Nursing Component
Delaware Valley GEC
Nursing Education Bldg., Room 412
University of Pennsylvania
Philadelphia, PA 19104
(215) 898-8802

Ann Sweeney, M.A.
Assistant Director
Resources Mgmt. and Research
Mississippi GEC
University of Mississippi
Alumni House, Room #319
2500 North State Street
Jackson, MS 39216
(601) 984-6190/6188

Jodi Teitelman, Ph.D.
Training Director
Virginia Commonwealth Univ. GEC
Box 228 MCV Station
Richmond, VA 23298-0228
(804) 786-8906

Paula D. Thomas, M.S.N., R.N.-C.
Program Coordinator
New Mexico GEC
Room 719A, Nursing/Pharmacy Bldg.
University of New Mexico
Albuquerque, New Mexico 87131
(505) 277-5134

Lorraine Thompson
Administration of Aging
Health & Human Services
North Building, Room 4266
330 Independence Ave., S.W.
Washington, D.C. 20201
(202) 245-0441

Joel Ann Tod, M.A.
Project Director
Technical Resources, Inc.
3202 Monroe Street
Rockville, Maryland 20852
(301) 231-5250

Lucia Torian, Ph.D.
Hunter/Mount Sinai GEC
Brookdale Center on Aging
425 E. 25th Street
New York, New York 10010
(212) 481-4349

Ames Tryon, D.D.S., Ph.D.
Executive Director
Mississippi GEC
Medical Alumni House
3rd Floor, Suite 321
Univ. of Mississippi Medical Center
2500 North State Street
Jackson, Mississippi 39216-4505
(601) 984-6190

Otto Van Duyn, Ph.D.
Co-Project Director
Texas Consortium of GECs
College of Pharmacy & Health Sciences
Texas Southern University
3011 Cleburne Street
Houston, TX 77004
(713) 630-0337

Timothy VanSusteren, Ph.D.
Evaluation Specialist
Midwest GEC
Medical College of Wisconsin
8701 Watertown Plank Road
Milwaukee, WI 53226
(414) 257-8536/8736

James E. C. Walker, M.D.
Associate Director
Univ. of Connecticut GEC
Univ. of Connecticut Health Center
Farmington Avenue
Farmington, CT 06032
(203) 679-3956/3960

Robert Wallace, M.D.
Co-Director
Iowa GEC
Dept. of Preventive Medicine
2850 SB, University of Iowa
Iowa City, Iowa 52242
(319) 335-8999

Joan B. Wood, Ph.D.
Educational Services Director
Virginia Commonwealth Univ. GEC
Box 228 MCV Station
Richmond, VA 23298-0228
(804) 786-8903

Teresa Wright, B.S.
Assistant to Project Director
Texas Consortium of GECs
Baylor College of Medicine
One Baylor Plaza, Room M320
Houston, TX 77030
(713) 798-6470

Gwen Yeo, Ph.D.
Director, Stanford GEC
703 Welch Road, Suite H-1
Stanford, CA 94305
(415) 725-4489